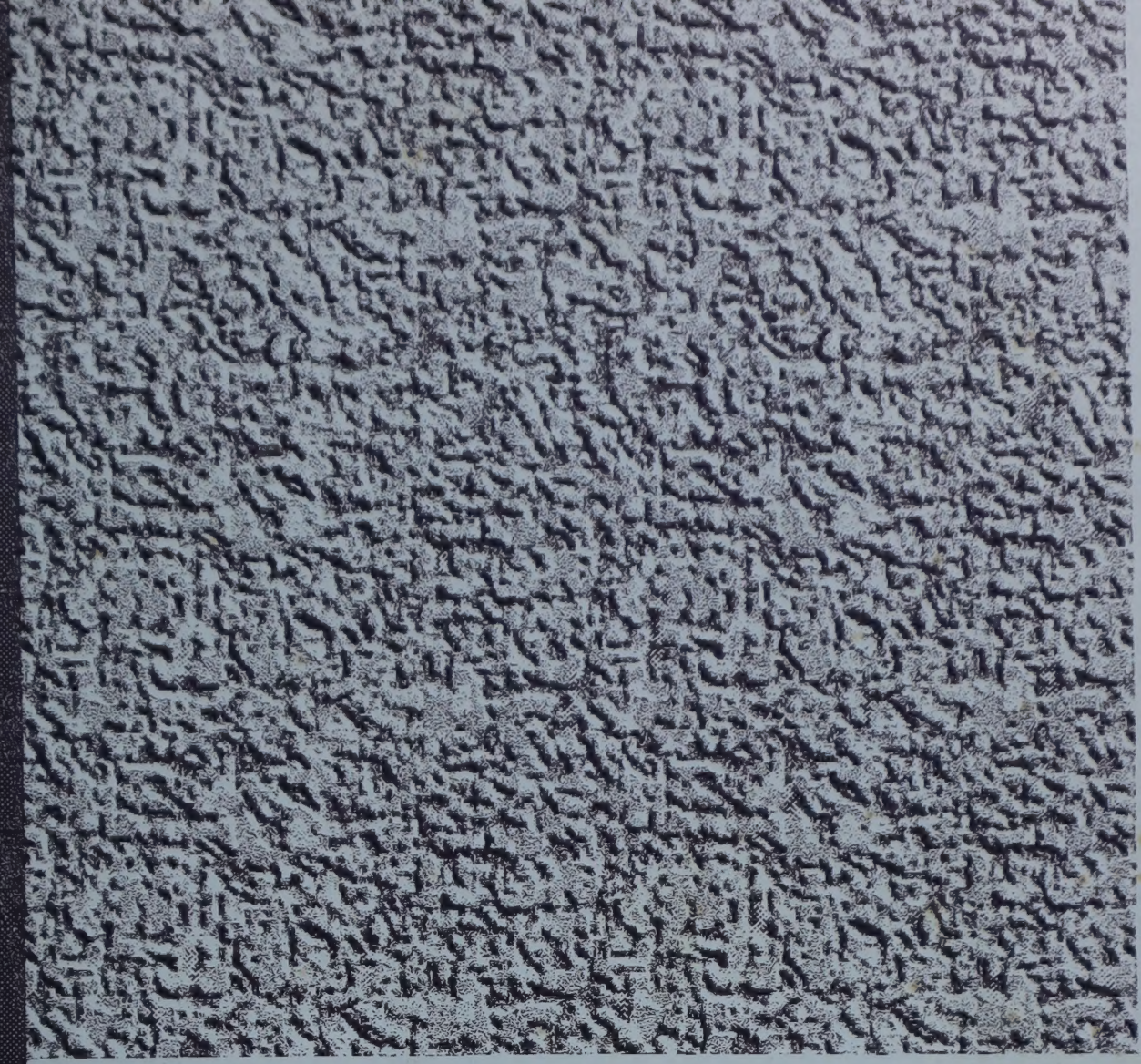


A report on the

Concurrent Evaluation of the RUHSA HIV/AIDS Awareness Programme

5890

Community Health Cell
Library and Documentation Unit
367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala

A REPORT
ON THE
CONCURRENT EVALUATION
OF THE

RUHSA HIV/AIDS AWARENESS PROGRAMME

Undertaken by
Cathy Hill
Ruth Turpie
Lijan Tran

From the
University of South Australia
St Bernards Road
Magill, South Australia
AUSTRALIA 5072

In conjunction with
RUHSA Department
Christian Medical College and Hospital
North Arcott Ambedkar District
Tamil Nadu
SOUTH INDIA
632 209

© 1997

ISBN 0 909215 62 6

DIS-325
05893 N97

EVALUATION TEAM

Dr. Rajaratnam Abel, MBBS, MPH.....Head, RUHSA Department, CMCH
Mr. Selvakumar, MA, DCHM, PGDPC.....Coordinator
Mrs. Jolly Rajaratnam, MSc .....Computer Systems Mang.
Mr Stalin Gnanasigamani .....Health Educator GrII
Ms. Cathy Hill.....Member
Ms. Ruth Turpie, BA.....Member
Ms. Lijan Tran.....Member
Mr. Philip Manikam .....Data Collection & Collation
Mr. P. John Lee Franko.....Data Collection & Collation
Mr. Raja Pandi.....Data Collection & Collation

TABLE OF CONTENTS

ACKNOWLEDGMENTS 6

SUMMARY OF FINDINGS 7

MAP OF KV KUPPAM BLOCK 9

INTRODUCTION 10

DESCRIPTION OF THE CURRENT RUHSA HIV/AIDS AWARENESS PROGRAMME 11

HIV/AIDS AWARENESS PROGRAMME OBJECTIVES 13

TERMS OF REFERENCE 15

EVALUATION OBJECTIVES 16

GENERAL METHODOLOGY 17

PREPARATORY PHASE 18
FINALISING EVALUATION PROGRAMME, OBJECTIVES AND METHODOLOGY 18
EVALUATION PROCESS, INTERVIEWS AND DATA COLLECTION 18
DATA COLLATION, EDITING AND ANALYSIS 18
REPORT WRITING 18
PRESENTATION OF EVALUATION REPORT (1ST DRAFT) 18
PRESENTATION OF FINAL REPORT TO HEAD OF RUHSA DEPARTMENT 18

RESULTS 19

DISCUSSION 51

RECOMMENDATIONS 57

LIMITATIONS 59

REFERENCES 60

APPENDIX 61

RUHSA HIV/AIDS AWARENESS PROGRAMME EVALUATION 61
INTERVIEW SCHEDULE 61

RUHSA DEPARTMENT, CMCH, AIDS AWARENESS PROGRAMME 66

PROGRAMME INTENSITY TABLE 66

ACKNOWLEDGMENTS

The University of South Australia and RUHSA Department would sincerely like to thank everyone who contributed to the evaluation.

Firstly, thanks are extended to the **Christian Medical College and Hospital** as the parent organisation of RUHSA.

Thanks are extended to M. Philip, P. John Lee Franko and Raja Pandi of Bishop Heber College, Tiruchirappalli for their tireless and patient contribution to the data collection and collating. Their role as interpreters was of invaluable assistance.

Thanks are also extended to Mr. Subash and Mr. Jaya Raman, Rural Community Officers, and Ms. Baby Reeta and Ms Dhana Lashmi, Health Aides, for their help and knowledge imparted in the data collection process in the respective villages.

Gratitude is extended to the Family Care Volunteers, Ms Selvi, Ms Vatchala and Ms Jayakodi who freely gave of their time and provided valuable assistance in the data collection phase in the respective villages.

Thanks are also extended to all the respondents who so kindly gave their time and knowledge in answering the questions. Without their contribution the evaluation would not have been possible.

Finally we express our gratitude to God for the opportunity of learning from the evaluation and working together safely and successfully as a team.

SUMMARY OF FINDINGS

A cross sectional interview was implemented to evaluate the effectiveness of the RUHSA HIV/AIDS awareness programme within the population of KV Kuppam Block, Tamil Nadu, India. The sample of the evaluation consisted of 176 respondents.

The RUHSA campaign (11.4%) was the highest source of HIV/AIDS awareness for the respondents apart from the mass media which included, television (61.9%), radio (26.7%) and newspaper (14.2%).

When the respondents were specifically asked had RUHSA been involved in their HIV/AIDS education, 28.4% stated that RUHSA had been involved. The increase when respondents were asked directly about RUHSA's involvement placed the RUHSA campaign as the second highest source of HIV/AIDS education in KV Kuppam Block.

In Latteri, the village of the highest intensity RUHSA HIV/AIDS programme, 45.5% of the respondents had seen the RUHSA programme. In Pillandipattu, the village with the lowest intensity programme, 29.8% of the respondents had seen the RUHSA programme.

In Pallathur, the village with medium programme intensity, 12.5% had seen the RUHSA programme. The video programme (60.0%) was the most widely seen RUHSA method of HIV/AIDS awareness followed by the cultural programme (24.0%), public meeting (14.0%), pamphlet (12.0%) and the rally (10.0%). The preferred RUHSA method of HIV/AIDS education was the video (10.8%) followed by the pamphlet (8.5%).

Slightly over half of the surveyed population (54.0%) knew HIV/AIDS was a fatal disease. The knowledge as to whether a person with HIV/AIDS will die increased as the respondents' educational status increased. 62.5% of the population knew HIV/AIDS was present in Tamil Nadu compared to 22.7% who knew HIV/AIDS was present in KV Kuppam Block. More males than females knew the prevalence of HIV/AIDS. The knowledge of the prevalence of HIV/AIDS appeared to correspond to the education level of the respondent. Respondents who had higher levels of education stated more correctly the prevalence of HIV/AIDS.

HIV was attributed by 14.8% of the sample population as being the cause of AIDS whilst 8.0% stated the cause as the AIDS virus. The cause of AIDS was not known by 72.7% of the respondents. The education level of the respondents related to the accuracy of the cause of AIDS.

Sexual intercourse (54.0%) was the most known method of transmission of HIV/AIDS followed by infected needles, blades and syringes (31.8%), blood transfusions (31.3%) and perinatal transmission (8.5%). More males than females knew the methods of transmission of HIV/AIDS. The higher the level of education of the respondent corresponded to an increased knowledge of the methods of transmission of HIV/AIDS.

One quarter of the respondents (25.0%) stated HIV/AIDS was transmitted by shaking hands whilst 35.2% of respondents stated HIV/AIDS was transmitted by sharing cups, plates and clothing. Less females than males thought HIV/AIDS was transmitted by such methods.

HIV/AIDS was stated to be curable by 16.5% of the sample population. More females than males did not know if HIV/AIDS was curable. Knowledge concerning the curability of HIV/AIDS increased with the increased educational level of the respondent.

A blood test was stated by 52.8% of the respondents as being the method of detecting HIV/AIDS whilst only 1.7% knew the actual name of the test used to be Elisa. More males than females knew the test used to detect HIV/AIDS. The higher the education level of the respondent the increased accuracy of knowledge regarding the test used to detect HIV/AIDS.

Few respondents knew the signs and symptoms of HIV/AIDS. 62.5% of the respondents did not know any sign or symptom of HIV/AIDS. Weight loss(26.1%) was the most commonly known symptom followed by fever (16.5%) and skin diseases (8.0%).

The most commonly stated methods of prevention of HIV/AIDS were no premarital sex (34.7%), monogomy (33.5%), sterile needles, syringes and blades (14.2%) and condoms (11.9%). More females (46.5%) than males (28.9%) did not know any methods of

prevention of HIV/AIDS. The respondents aged between 20 to 29 years generally stated more methods of prevention than other age groups. The majority of respondents (44.9%) stated HIV/AIDS education should begin between the ages of 11 and 19 years. The majority of respondents (48.3%) stated condom education should be included in HIV/AIDS education. More males than females stated condom education should be included with HIV/AIDS education. Doctors (47.2%) were the best persons stated by the respondents to educate others about HIV/AIDS followed by teachers (15.9%), social workers (13.6%) and RUHSA (5.1%).

Pleasure (27.3%) was stated by respondents as being the main reason for people engaging in sex before marriage followed by puberty (12.5%) and family upbringing (8.0%) whilst 43.8% of all respondents did not know the reason why people engaged in premarital sex. Conflict with spouse (18.8%) was stated as the main reason why people engaged in sex with a person other than the spouse, followed by pleasure (16.5%) and dissatisfaction with spouse (14.2%) whilst 48.3% of respondents did not know any reasons why people engage in extra marital sex.

High risk behaviour and activities appeared to be occurring in the villages to varying degrees. Although 66.5% of the respondents did not know or stated no persons were engaging in premarital sex 33.4% gave varying numbers of persons engaging in premarital sex. Similar responses were obtained from the respondents concerning the number of people engaging in extra marital sex. Homosexual relationships appear to be relatively small in number. The majority of respondents (67.0%) stated they did not know if homosexuals were in the village followed by 29.5% of respondents who stated the number was zero. The majority of respondents (81.8%) stated there were no commercial sex workers in the village or the respondent did not know the number of commercial sex workers. Similar responses were stated regarding the number of commercial sex workers that go to other towns or villages to practice. Latteri was the village which respondents stated had the higher incidence of high risk activities.

The number of respondents who asked the doctor to use a sterile needle was 43.8%, whilst 36.4% do not ask the doctor to use a sterile needle. The number of respondents who take sterile needles to the doctor was 37.5% compared to 43.2% of respondents who do not take sterile needles to the doctor. The number of respondents who knew the barber used a new blade was 38.1% whilst 26.1% stated the barber did not use a new blade and 28.4% did not know. The number of respondents that stated the level of improper sex in the village had decreased in the last twelve months was 21.0%, whilst 26.7% stated the incidence had increased and 43.8% did not know.

Condoms were thought to be 100% effective against the transmission of HIV/AIDS by 30.1% of respondents, whilst 24.4% stated condoms were not 100% effective. According to the respondents, 26.7% stated condoms were available in the village whilst 27.3% stated condoms were not available and 46.0% did not know of the availability of condoms. More males than females knew of the availability of condoms.

Most respondents stated HIV/AIDS infected persons should be hospitalised (48.9%), whilst 21.0% stated the person should stay at home and 14.2% stated the person should be isolated.

Community awareness and education (35.8%) was the most suggested method for preventing HIV/AIDS followed by self control (19.3%), a cure should be found or the doctor should prevent HIV/AIDS (8.0%), monogomy (6.3%) and censoring movies and television (6.3%) were the following most suggested methods.

BLOCK BOUNDARY
PANCHAYAT BOUNDARY
MAIN ROAD
RAILWAY
PRIMARY HEALTH CARE CENTRE
C.S.U RUHSA

N

Pallathur
Panamandangi
Maliapattu
Senji
Kilmuttukuc
Kanguppam
Melmoil
Kalambut
Thondanthulasi
Arumbakkam
D.R. Kuppam
Murukampet
Angarankuppam
Nagal
Machanur
Alanganeri
Vadugan thangal
B.N. Palayam
Latteri
KATPADI
Sethuvandai
Kosavanpudur
P.K. Puram
K.V.K.
Veppaneri
GUDIYATHAM
Kilalathur
Chennanakupam
Annagudi
Vilundakkai
KATPADI
Pillandi pattu
Velambut
Sozhamur
Kavanur
Mudinampet
Thirumani
Netteri
Kavasambut
Ammanan Kuppam
Veppur
Pasumathur
JOLARPET
Kothamangalam

MAP OF KV KUPPAM BLOCK

INTRODUCTION

HIV/AIDS is a rapidly spreading disease which has the potential to cause massive loss of lives. Tamil Nadu has the third highest reported number of HIV/AIDS cases in India. **The Hindu** (14.4.97) reported a recent survey found Tamil Nadu had 879 people infected with AIDS.

KV Kuppam Block is not isolated from HIV/AIDS, ten cases of HIV/AIDS have been detected at RUHSA to date. Ultimately there could be as many as 600 infected people in the KV Kuppam Block, The Tamil Nadu State AIDS Control Society (TNSACS) has suggested that as many as 0.5 per cent of the population of Tamil Nadu are infected with HIV/AIDS (**The Hindu**, 14.4.97). RUHSA's commitment to health and development for the last twenty years has continued and the implementation of a HIV/AIDS awareness programme in the KV Kuppam Block was seen as a critical step in tackling the HIV/AIDS epidemic.

As a result of the growing concern and awareness of HIV/AIDS RUHSA implemented a structured HIV/AIDS awareness programme in 1996. The programme includes training, education and evaluation. The current evaluation is the first yearly evaluation and is included in the programme time plan.

Previous HIV/AIDS awareness programmes in the KV Kuppam Block consisted of the Government Primary Health Care Centre's orientation and training course of which one course is conducted per year in only one village. The duration of the Government Primary Health Centre's course has spanned three years and RUHSA has been contracted to implement the course on the three occasions the course has been conducted.

An additional programme was implemented by RUHSA after a Diploma of Community Health Management student undertook a study on HIV/AIDS awareness in 1994. Based on the findings of the study, a group education programme was conducted in Pasumathur. The selected groups included women, adolescent girls, adolescent boys, 8th standard students and teachers. Additionally the first barber training programme and first mass education campaign were implemented in 1994 utilising media including exhibitions, song, dance and poetry.

Since 1977 RUHSA has maintained a committed approach to health and development in the KV Kuppam Block which consists of thirty nine panchayats in the North Arcott Ambedkar District of Tamil Nadu, India. The population of KV Kuppam Block in 1996 was 114,492 with the average household size being 4.7. 1992 statistics indicate 83.2% of the population reside in nuclear and extended family units. 58% of the population reside in the main villages whilst 22.1% reside in colonies and 19.8% reside in field huts (RUHSA, 1992). The scattered residences of the population has created some difficulty in the HIV/AIDS programme reaching some members of the population.

In 1983 over 50% of the population lived below the poverty line. 29.7% of the population had received no formal education whilst 25% of the population had received less than 5th standard of education. The majority of the population of KV Kuppam Block are employed in general and agricultural cooli work or agricultural oriented occupations (RUHSA 1983). The nature of employment and low levels of literacy have posed some difficulties in the HIV/AIDS awareness programme.

The most prevalent health issues affecting the population of KV Kuppam Block include diarrhoea, tuberculosis, cardiac problems, bronchial pneumonia and diabetes (RUHSA, 1997). There is a general acceptance of allopathy by the population of KV Kuppam Block. Herbal health remedies still remain utilised by some of the population.

DESCRIPTION OF THE CURRENT RUHSA HIV/AIDS AWARENESS PROGRAMME

The current RUHSA HIV/AIDS awareness programme was implemented in 1996 in KV Kuppam Block, North Arcott Ambedkar District, Tamil Nadu, India. No external funding is utilised in the HIV/AIDS awareness programme. Funding is derived from the annual RUHSA budget and the operational income generated by RUHSA.

The aim of the HIV/AIDS awareness programme is to educate the general community of KV Kuppam Block on HIV/AIDS through the imparting of knowledge via various media. The medias include exhibitions, videos, puppetry, pamphlets, booklets, rallies, audio tapes, public meetings, and cultural programmes. Selected people are also utilised for the programme and include the HIV/AIDS awareness Programme Coordinator, doctors, nurses, Rural Community Officers, Family Care Volunteers, barbers, selected groups and guest speakers.

The high risk groups of the population of KV Kuppam Block include commercial sex workers, construction workers, truck drivers, shoe factory workers, security personnel and the families of high risk groups. The RUHSA HIV/AIDS awareness programme has been a more broad based and far reaching education and awareness programme encompassing the majority of the community (including young people from 8th standard onward), rather than focussing solely on high risk groups. The targeted population is people aged between thirteen and seventy years of age.

The goal of the HIV/AIDS awareness programme is to keep the incidence of HIV/AIDS as low as possible by imparting knowledge and creating awareness. It is foreseen that through community education, behavioural changes pertaining to high risk behaviour will result. The foreseen behaviour change is expected to reduce the incidence of HIV/AIDS.

The programme has been implemented using the various methods and medias mentioned previously. Community based education is viewed as imperative, with a particular emphasis on a campaign approach, school based education and a multi strategy approach. Additionally RUHSA provides diagnostic, counselling, referral and support services.

The initial HIV/AIDS awareness programme in 1996 was a one day campaign method utilising a PA system in a selected strategic village. Group education was later introduced utilising guest speakers which provided status to the campaign.

Further changes included the cessation of using local leaders in public meetings due to the intended message not always being successfully conveyed. The local leaders were then utilised in the planning of cultural programmes.

The attention span of the audience created some issues and changes were implemented to create greater audience attention including a one hour video and puppet show.

Local villagers were gradually included in the education and planning of the awareness programme. Rural Community Officers (RCOs) and Family Care Volunteers (FCVs) are also utilised as facilitators and provide assistance in an organisational capacity.

The villages and colonies of KV Kuppam Block can be divided in terms of the intensity of HIV/AIDS awareness received to date and are accordingly villages of high, medium or low programme intensity. Villages and colonies of high programme intensity have been exposed to all mediums of awareness with the exception of the puppet show. Villages and colonies of medium programme intensity have not been exposed to the rally and the programme is of a shorter time duration and less intense in nature. Villages and colonies of low programme intensity are villages and colonies that have an evening programme only, consisting of a video and public meeting. Refer to appendix 2 for Programme Intensity Table.

Preceding the HIV/AIDS awareness programme, RUHSA organised and conducted a seminar in March 1995. Invitations were also extended to non government organisations involved in HIV/AIDS programmes. The seminar provided an opportunity for professionals involved with HIV/AIDS programmes to share knowledge and experiences. Ten RUHSA

staff participated in the seminar and the subsequent overall planning for the current HIV/AIDS awareness programme followed.

The Programme Coordinator has an extensive knowledge of HIV/AIDS and methods of education. Education and knowledge of the subject have been obtained via lectures, literature, audio visual aides, experts, HIV+ people and visiting various projects. Additionally the Programme Coordinator has a Bachelor of Science, Masters in Economics, Diploma in Health Education and a Bachelor of Education.

The Rural Community Officers are also educated about HIV/AIDS and act as the organisers in the field and also provide a welcome address. One Rural Community Officer is trained in puppetry.

Family Care Volunteers are utilised for communicating messages about HIV/AIDS in the course of general health care duties undertaken in the villages and colonies. Family Care Volunteers have also been educated about HIV/AIDS by RUHSA.

RUHSA trainees are involved in the provision of the cultural programmes, particularly song, dance and drama with a pertinent HIV/AIDS message.

HIV/AIDS AWARENESS PROGRAMME OBJECTIVES

The objectives of the HIV/AIDS awareness programme in the targeted population as stated in the RUHSA programme outline are as follows:

(A) At the end of the education programme of the people in KV Kuppam Block aged between thirteen to seventy years:

1. 100% will be able to state the cause of HIV/AIDS.
2. 80% will be able to list four methods of the spread of HIV/AIDS.
3. 80% will be able to list five methods of prevention in the spread of HIV/AIDS.
4. 100% will be able to state that there is no cure at present for HIV/AIDS.
5. 80% will be able to list at least four ways in which HIV/AIDS does not spread.
6. 50% will be able to state at least two major symptoms of HIV/AIDS.
7. 50% will be able to state at least three minor symptoms of HIV/AIDS.
8. 60% will be able to discuss the role of condoms in HIV/AIDS prevention.
9. 40% will be able to state the concepts of HIV/AIDS.
10. 80% will be able to promote fidelity both within and outside marriage.
11. 60% will be able to increase in condom use in high risk groups.

(B) At the end of the education programme at least 80% of adolescents/youths will be able to

1. Describe the anatomical and the physiological changes at puberty.
2. Discuss the psycho social changes occurring at puberty.
3. State the importance of social control on pre sexual activities.

(C) 75% of parents of adolescent children will:

1. Be aware of their adolescent children's spending, social and sleeping habits and pattern of adolescents.
2. Communicate with them to know and advise on correct behaviour.

(D) Develop facilities initially for screening of blood.

(E) Carry out prevalence studies by anonymous testing of untagged blood from pregnant women and others.

(F) Provide counselling support for pre and post HIV/AIDS tests and for HIV/AIDS positive patients.

(G) Facilitate the establishment of community based care for HIV/AIDS cases as they gradually increase.

1. Encourage families to accept relatives who are HIV/AIDS positive.
2. Provide moral and social support to HIV/AIDS positive family members and provide care at home.

(H) To conduct research in various approaches to behavioural changes in the community.

(I) To establish linkages with institutions and organisations involved in HIV/AIDS education and control.

(J) To facilitate human resource development opportunities for staff to keep pace with current epidemiology, diagnosis, methods of prevention and community based care.

(K) To document available data and successful strategies and publish through available opportunities strategies of counselling and preventing HIV/AIDS. (RUHSA, 1995)

TERMS OF REFERENCE

The following terms of reference were framed in consultation with the Head of RUHSA Department and the Evaluation Coordinator. The final terms of reference were confirmed before implementing the evaluation and are as follows:

1. The evaluation is concurrent and predetermined to occur one year after the initial implementation of the HIV/AIDS awareness programme.

2. The focus of the evaluation is to determine the effectiveness of the RUHSA HIV/AIDS awareness programme within the general community of KV Kuppam Block.

3. To determine the community knowledge and the extent of change in knowledge of HIV/AIDS within the KV Kuppam Block.

4. To identify the community's perception of the extent and possible influencing factors of high risk behaviour within KV Kuppam Block.

5. To determine the community's attitude toward HIV/AIDS infected people.

6. To provide future direction to RUHSA in HIV/AIDS awareness programmes.

7. The evaluation will be conducted between 3rd March 1997 and 31st March 1997.

8. The report of the evaluation will be submitted to the Head of RUHSA Department by 5th May 1997.

EVALUATION OBJECTIVES

The objectives for the evaluation were determined to be consistent with the terms of reference and are as follows:

1. Assess the change in knowledge, attitude and practice of the general community of KV Kuppam Block attributable to the HIV/AIDS awareness programme implemented by RUHSA.

2. Identify numbers regarding high risk behaviours including commercial sex workers, those engaging in pre marital sex and sex with a person other than their spouse and homosexual sex.

3. Identify possible influencing factors for changing sexual behaviour in people.

4. Identify the community's attitude to condom education and condom availability.

5. Identify the source of HIV/AIDS education for the community of KV Kuppam Block, including the extent of RUHSA's involvement in awareness programmes.

6. Obtain suggestions for appropriate HIV/AIDS awareness programmes from the community of KV Kuppam Block.

GENERAL METHODOLOGY

The process and time plan of the evaluation is shown diagrammatically below.

1. PREPARATORY PHASE	**22nd - 26th Feb 1997**	**At RUHSA**
↓		
2. FINALISING EVALUATION PROGRAMME, OBJECTIVES AND METHODOLOGY	**26th Feb-4th Mar 1997**	**At RUHSA**
↓		
3. EVALUATION PROCESS INTERVIEWS, DATA COLLECTION	**5th - 10th Mar 1997**	**At Latteri, Pallathur & Pillandipattu**
↓		
4. DATA COLLATION, EDITING AND ANALYSIS	**11th Mar-12th Apr 1997**	**At RUHSA**
↓		
5. REPORT WRITING	**1st Apr - 2nd May 1997**	**At RUHSA**
↓		
6. PRESENTATION OF EVALUATION REPORT (1ST DRAFT) & CONSULTANCY	**2nd May 1997**	**At RUHSA**
↓		
7. PRESENTATION OF FINAL REPORT TO THE HEAD OF RUHSA DEPARTMENT	**5th May 1997**	**At RUHSA**

PREPARATORY PHASE

During the preparatory phase the HIV/AIDS awareness programme was selected as the project for evaluation in consultation with the Head of RUHSA Department. Mr Selvakumar was entrusted with the responsibility of Evaluation Coordinator. Discussion occurred with Mr Stalin, Programme Coordinator pertaining to details of the HIV/AIDS awareness programme. The HIV/AIDS awareness programme outline was obtained. The time frame was agreed upon by the relevant parties involved in the evaluation.

FINALISING EVALUATION PROGRAMME, OBJECTIVES AND METHODOLOGY

During the second phase the evaluation objectives and terms of reference were finalised and agreed upon in consultation with the Head of RUHSA Department and the Evaluation Coordinator. The interview schedule was designed, modified, pretested on three interviewees and modified again before being agreed upon by the relevant parties.

The sampling design was undertaken and three villages were randomly selected from villages of high, moderate and low programme intervention. The village of high intervention was Latteri, moderate intervention was Pallathur and Pillandipattu represented the village with low intervention. As the target sample population was sixty persons from each of the three villages a starting number was randomly selected followed by systematic selection of the households. Latteri has a population of 6,705, Pallathur 960 and Pillandipattu 1,433.

EVALUATION PROCESS, INTERVIEWS AND DATA COLLECTION

The evaluation team proceeded firstly to the village of Latteri followed by Pallathur and finally Pillandapattu. The interview schedule provided the basis for the interview and subsequent data collection. Rural Community Officers, Family Care Volunteers and Health Aides facilitated in locating the sample population. The evaluation team worked in three separate groups during the interview and data collection phase, and were overseen by the Evaluation Coordinator. Each interviewing group consisted of one person from the School of Social Work and Social Policy, University of South Australia, and one person from Bishop Heber College, Tiruchirappalli. Rural Community Officers, Health Aides and Family Care Volunteers were also assigned to each group.

DATA COLLATION, EDITING AND ANALYSIS

The data obtained via the interview process was coded and entered into the d-base computer programme (Foxplus). The subsequent computer printout was edited and errors rectified. The evaluation team then undertook analysis of the data.

REPORT WRITING

The draft evaluation report was written by Cathy Hill and edited by the Head of RUHSA Department and Ruth Turpie.

PRESENTATION OF EVALUATION REPORT (1ST DRAFT)

The evaluation team submitted the first draft of the evaluation report to the Head of RUHSA Department.

PRESENTATION OF FINAL REPORT TO HEAD OF RUHSA DEPARTMENT

Following consultation with the Head of RUHSA Department and subsequent editing the final evaluation report was submitted to the Head of RUHSA Department

RESULTS

A total of 176 respondents were interviewed for the evaluation. The list of villages surveyed and the number of respondents from the villages is presented in Table 1, according to the respondents. More males than females were surveyed in the villages of Pallathur and Latteri whilst more females than males were surveyed in the village of Pillandipattu.

Table 1: ***List of villages surveyed according to the sex of the respondent.***

	Male		Female		Total	
Village	**No**	**%**	**No**	**%**	**No**	**%**
Pallathur	35	38.9	29	33.7	64	36.4
Latteri	32	35.6	23	26.7	55	31.2
Pillandipattu	23	25.5	34	39.6	57	32.4
TOTAL	90	100.0	86	100.0	176	100.0

In Table 2 the socioeconomic characteristics of the respondents are shown. Of 176 respondents 9.1% were in the age group 14 - 19 years, 23.9% were aged 20 -29 years, 27.8% were aged between 30 - 39, 23.3 % were aged between 40 - 49 and 15.9% of the respondents were aged above 50 years. The proportion of male respondents (51.1%) was marginally higher when compared to female respondents (48.9%).

The education level of the respondents was generally evenly distributed except in the areas of higher education. The number of the respondents that had received no formal education was 22.7%, whilst 23.3% had achieved between 1st and 5th standard of education, 23.3% had achieved between 6th and 8th standard of education whilst 26.7% had achieved between 9th and 12th standard of education.

Only 3.4% of the respondents had achieved Diploma status in education and 0.6% of respondents had achieved Degree status.

The majority of respondents were employed in agriculture (25.0%), labouring (21.0%) and home duties (21.0%).

The backward caste represented the majority of the respondents (57.4%), the scheduled caste represented 41.5 % of the respondents whilst the forward caste comprised 1.1% of the respondents.

The roof type of the respondent's home was generally evenly distributed. 36.9% of respondents had a thatched roof, 32.4% had a tiled roof and 30.7% of respondents had a terraced roof.

Table 2: ***Distribution of respondents according to socio economic characteristics.***

(N =176)

1. Age group

Age	No	%
14-19	16	9.1
20-29	42	23.9
30-39	49	27.8
40-49	41	23.3
Over 50	28	15.9

2. Sex

	No	%
Male	90	51.1
Female	86	48.9

3. Education

	No	%
No education	40	22.7
1st - 5th standard	41	23.3
6th - 8th standard	41	23.3
9th - 12th standard	47	26.7
Diploma	6	3.4
Bachelors Degree	1	0.6

4. Occupation

	No	%
Agriculture/farmer	44	25.0
Coolie	37	21.0
Beadie Roller	14	8.0
Unemployed	10	5.7
House (Home duties)	37	21.0
Barber	2	1.1
Student	6	3.4
Grocer	1	0.6
Thatcher	1	0.6
Business	5	2.8
Tailor	2	1.1
Driver	2	1.1
Miller	2	1.1
Dobi	1	0.6
Retired	5	2.8
Milk seller	1	0.6
Railways	1	0.6
Nutritionist	1	0.6
Electrician	2	1.1
Nurse	1	0.6
CRPF	1	0.6

5. Caste

	No	%
Scheduled caste	73	41.5
Backward caste	101	57.4
Forward caste	2	1.1

6. Roof

	No	%
Thatched	65	36.9
Tiled	57	32.4
Terraced	54	30.7

The distribution of respondents who had heard about HIV/AIDS is presented in Table 3. The majority of the respondents (75.0%) had heard about HIV/AIDS. More male respondents (83.3%) had heard about HIV/AIDS compared to 66.3% of female respondents.

A significant relationship was found between "having heard about HIV/AIDS" and "sex", χ^2 (1) = 6.822, p = .009. A post hoc test revealed that this was a weak relationship which accounted for 20% of the variance.

Table 3: ***Distribution of respondents who have heard about HIV/AIDS according to the sex of the respondent.***

	Male		Female		Total	
Heard about HIV/AIDS	**No**	**%**	**No**	**%**	**No**	**%**
Yes	75	83.3	57	66.3	132	75.0
No/don't know	15	16.7	29	33.7	44	25.0
TOTAL	90	100.0	86	100.0	176	100.0

Table 4 presents the distribution of responses according to the sources of HIV/AIDS information. The majority of respondents had seen HIV/AIDS information via the mass media, including television (61.4%), radio (26.7%) and newspaper (14.8%). The largest source of HIV/AIDS information, excluding the mass media, was obtained from RUHSA (11.4%). Significantly more respondents (39.1%) from the village of Pallathur had not seen any source of HIV/AIDS information in comparison to Latteri (14.5%) and Pillandipattu (15.8%).

Table 4: ***Distribution of sources of HIV/AIDS according to the village of the respondent.***

	N=64 Pallathur		N=55 Latteri		N=57 Pillandipattu		N=176 TOTAL	
Source of HIV/AIDS information	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Radio	14	21.9	18	32.7	15	26.3	47	26.7
Television	32	50.0	40	72.7	37	64.9	109	61.9
Newspaper	3	4.7	15	27.3	7	12.3	25	14.2
School/children	0	0.0	2	3.6	3	5.3	5	2.8
Books	0	0.0	5	9.1	4	7.0	9	5.1
Posters	0	0.0	1	1.8	0	0.0	1	0.6
RUHSA	4	6.3	10	18.2	6	10.5	20	11.4
Friends	3	4.7	6	10.9	2	3.5	11	6.3
Hospital	0	0.0	1	1.8	4	7.0	5	2.8
Workplace	0	0.0	3	5.5	0	0.0	3	1.7
Nurses	0	0.0	0	0.0	1	1.8	1	0.6
Not applicable	25	39.1	8	14.5	9	15.8	42	23.9

The distribution of respondents who had seen RUHSA's HIV/AIDS awareness programme according to the village of residency is depicted in Table 5. Latteri (45.5%) was the village that had the most respondents who had been exposed to RUHSA's HIV/AIDS awareness programme, followed by Pillandipattu (29.8%) and Pallathur (12.5%).

A significant relationship was found between "exposure to HIV/AIDS awareness programme" and "village", χ^2 (4) = 21.056, p = .0003. A post hoc test revealed that this was a moderate relationship which accounted for 35% of the variance.

Table 5: ***Distribution of exposure to RUHSA HIV/AIDS awareness programme according to the village of the respondent.***

	N=64 Pallathur		N=55 Latteri		N=57 Pillandipattu		N=176 TOTAL	
Exposed to RUHSA HIV/AIDS Awareness Programme	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	8	12.5	25	45.5	17	29.8	50	28.4
No	39	60.9	28	50.9	36	63.2	103	58.5
Don't Know	17	26.6	2	3.6	4	7.0	23	13.1
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

Table 6 shows the distribution of RUHSA's HIV/AIDS awareness programme methods as seen by the respondents. The majority of responses (60.0%) indicated seeing the video programme. More females (65.0%) had seen the video in comparison to males (56.7%). The cultural programme (24.0%) was the second most seen RUHSA method followed by public meeting (14.0%), pamphlet (12.0%) and rally (10.0%). More males (33.3%) had seen the cultural programme than females (10.0%). More males (20.0%) had seen the public meeting in comparison to females (5.0%). More females (15.0%) had seen the pamphlets in comparison to males (10.0%). More males (13.3%) had seen the rally in comparison to females (5.0%). Equal numbers of females had seen RUHSA's books, rally, public meeting, school visit and tailoring programme.

Table 6: ***Distribution of RUHSA awareness methods seen according to the sex of the respondents.***

	N=30 Male		N=20 Female		N=50 Total	
Type of method seen	**No**	**%**	**No**	**%**	**No**	**%**
Exhibition	2	6.7	0	0.0	2	4.0
Video	17	56.7	13	65.0	30	60.0
Puppet Show	1	3.3	0	0.0	1	2.0
Pamphlet	3	10.1	3	15.0	6	12.0
Books	2	6.7	1	5.0	3	6.0
Rally	4	13.3	1	5.0	5	10.0
Public Meeting	6	20.0	1	5.0	7	14.0
Doctor	2	6.7	1	5.0	3	4.0
Cultural Programme	10	33.3	2	10.0	12	24.0
School	2	6.7	1	5.0	3	6.0
RUHSA Tailoring programme	2	6.7	1	5.0	3	6.0

Table 7 presents the distribution of responses concerning the preferred RUHSA HIV/AIDS awareness programme by the respondents who had witnessed RUHSA's programme. The video was the most popular method (10.8%) selected by the respondents. The video was also the most popular method for both males (12.2%) and females(9.3%). The pamphlet was the second highest preference for both males (11.1%) and females (5.8%). The cultural programme (6.3%) and the rally (5.7%) were the following preferred choices of the respondents

Table 7: ***Distribution of preferred RUHSA method of HIV/AIDS awareness programme according to the sex of the respondent.***

	N=90 Male		N=86 Female		N=176 Total	
Preferred method	**No**	**%**	**No**	**%**	**No**	**%**
Video	11	12.2	8	9.8	19	10.8
Pamphlet	10	11.1	5	5.8	15	8.5
Rally	9	10.0	1	1.2	10	5.7
Audio Tape	2	2.2	1	1.2	2	1.7
Doctor	1	1.1	1	1.2	2	1.1
Cultural Programme	8	8.9	3	3.5	11	6.3
Don't Know	3	3.3	0	0.0	3	1.7
Not applicable	61	67.8	69	80.2	130	73.9

Table 8 shows the distribution of respondents who had persons aged fourteen years and above residing in the house. The majority of the respondents had four persons (25.0%) aged fourteen years and above residing in the house followed by 2 persons (18.8%), three persons (15.3%) and one person (13.1%).

Table 8: ***Distribution of respondents according to number of persons aged 14 years and above residing in the home.***

No of persons aged 14 years or over	**No**	**%**
0 persons	16	9.1
1 persons	23	13.1
2 persons	33	18.8
3 persons	27	15.3
4 persons	44	25.0
5 persons	10	5.7
6 persons	5	2.8
7 persons	9	5.1
8 persons	4	2.3
9 persons	3	1.7
10 persons	2	1.1
TOTAL	176	100.0

The distribution of persons aged fourteen years and above in the respondent's home who had a knowledge of HIV/AIDS is depicted in Table 9. Two persons (18.8%) had the most responses for knowledge of HIV/AIDS followed by no persons (13.7%), three persons (12.5%) and one person (10.2%) and four persons also (10.2%)

Table 9: ***Distribution of the number of persons aged 14 years and above residing in the home of the respondent who have knowledge of HIV/AIDS.***

No of persons having knowledge of HIV/AIDS	No	%
0 persons	24	13.7
1 persons	18	10.2
2 persons	33	18.8
3 persons	22	12.5
4 persons	18	10.2
5 persons	3	1.7
6 persons	3	1.7
7 persons	6	3.4
8 persons	2	1.1
9 persons	2	1.1
10 persons	1	0.6
Don't Know	44	25.0
TOTAL	176	100.0

Table 10A and 10B depict the distribution of knowledge of the respondents as to whether a person with HIV/AIDS will die. Table 10a presents the responses according to the sex of the respondent. There was a trend of more males (62.2%) than females (45.3%) knew HIV/AIDS was a fatal disease. Of the total responses (54.0%) stated HIV/AIDS was fatal, whilst 18.8% stated that HIV/AIDS was not fatal and 27.3% did not know if HIV/AIDS was fatal.

No significant relationship was found between "knowledge about whether a person with HIV/AIDS will die" and "sex", χ^2 (2) =5.985, p = .05017.

Table 10A: ***Distribution of knowledge as to whether a person with HIV/AIDS will die, according to the sex of the respondent.***

	Male		Female		Total	
	No	%	No	%	No	%
Yes	56	62.2	39	45.3	95	54.0
No	16	17.8	17	19.8	33	18.8
Don't Know	18	20.0	30	34.9	48	27.2
TOTAL	90	100.0	86	100.0	176	100.0

Table 10B presents the responses according to the education level of the respondents. The higher the level of education of the respondent, the increased accuracy of the answer to the fatality of HIV/AIDS. The majority of respondents educated at 9th standard or higher (83.3%) stated HIV/AIDS was fatal compared to 56.1% educated between 6th to 8th standard, 41.5% educated between 1st to 5th standard followed by the respondents with no education (25.0%).

A significant relationship was found between "accuracy of answering" and "educational level", χ^2 (6) = 42.168, p < .001. A post hoc test revealed that this was a moderate relationship which accounted for 49% of the variance.

Table 10B: ***Distribution of knowledge as to whether a person with HIV/AIDS will die according to the educational level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Will a person with HIV/AIDS die	No	%	No	%	No	%	No	%
Yes	10	25.0	17	41.5	23	56.1	45	83.3
No	10	25.0	7	17.0	11	26.8	5	9.3
Don't Know	20	50.0	17	41.5	7	17.1	4	7.4
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

The distribution of knowledge of the respondents on the presence of HIV/AIDS in Tamil Nadu is presented in Table 11A and 11B. Table 11A presents the responses according to the sex of the respondent. More males (74.4%) stated HIV/AIDS was present in Tamil Nadu compared to females (50.0%). More females (37.2%) did not know if HIV/AIDS was present in Tamil Nadu compared to males (14.5%).

A significant relationship was found between "knowledge of presence of HIV/AIDS in Tamil Nadu" and "sex", χ^2 (2) = 12.092, p = .002. A post hoc test revealed that this was a weak relationship which accounted for 26% of the variance.

Table 11A: ***Distribution of knowledge on the presence of HIV/AIDS in Tamil Nadu according to the sex of the respondent.***

	Male		Female		Total	
Present in Tamil Nadu	**No**	**%**	**No**	**%**	**No**	**%**
Yes	67	74.4	43	50.0	110	62.5
No	10	11.1	11	12.8	22	11.9
Don't Know	13	14.5	32	37.2	45	25.6
TOTAL	90	100.0	86	100.0	176	100.0

Table 11B shows the responses according to the education level of the respondents. The higher the education level of the respondents the increased accuracy of the answer. The majority of respondents educated to 9th standard or above (88.8%) knew HIV/AIDS was present in Tamil Nadu followed by respondents educated between 6th to 8th standard (61.0%), 1st to 5th standard (56.1%)and respondents with no education (35.0%).

A significant relationship was found between "knowledge of the presence of HIV/AIDS in Tamil Nadu" and "education level", χ^2 (6) = 31.145, p = .00002. A post hoc test revealed that this was a moderate relationship which accounted for 42% of the variance.

Table 11B: ***Distribution of respondent's knowledge on the presence of HIV/AIDS in Tamil Nadu according to the education level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Present in Tamil Nadu	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	14	35.0	23	56.1	25	61.0	48	88.8
No	8	20.0	4	9.8	6	14.6	3	5.6
Don't Know	18	45.0	14	34.1	10	24.4	3	5.6
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

The distribution of knowledge of the respondents on the presence of HIV/AIDS in KV Kuppam Block is depicted in Table 12A and 12B. Table 12A presents the responses according to the sex of the respondents. More males (27.8%) knew HIV/AIDS was present in KV Kuppam Block compared to females (17.4%). More females (64.0%) did not know HIV/AIDS was present in KV Kuppam Block compared to males (40.0%).

A significant relationship was found between "knowledge of the presence of HIV/AIDS in KV Kuppam Block" and "sex", χ^2 (2) = 10.137, p = .0063. A post hoc test revealed that this was a weak relationship which accounted for 24% of the variance.

Table 12A: ***Distribution of knowledge on the presence of HIV/AIDS in KV Kuppam Block according to the sex of the respondent.***

	Male		Female		Total	
Present in KV Kuppam Block	**No**	**%**	**No**	**%**	**No**	**%**
Yes	25	27.8	15	17.4	40	22.7
No	29	32.2	16	18.6	45	25.6
Don't Know	36	32.2	55	64.0	91	51.7
TOTAL	90	100.0	86	100.0	176	100.0

Table 12B shows the responses according to the education level of the respondents. More respondents educated at 9th standard and above knew HIV/AIDS was present in KV Kuppam Block followed secondly by respondents with no education (22.5%). Respondents educated at 6th to 8th standard (17.1%)and respondents educated at 1th to 5th standard (17.1%) stated HIV/AIDS was present in KV Kuppam Block.

No significant relationship was found between "knowledge of the presence of HIV/AIDS in KV Kuppam Block" and "education level", χ^2 (6) = 13.3917, p = .0372.

Table 12B: ***Distribution of knowledge on the presence of HIV/AIDS in KV Kuppam Block according to the educational level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Present in KV Kuppam Block	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	9	22.5	7	17.1	7	17.1	17	31.5
No	6	15.0	9	22.0	10	24.4	20	37.0
Don't Know	25	62.5	25	60.9	24	58.5	17	31.5
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

Table 13A and 13B present the distribution of knowledge of the respondents according to the cause of AIDS. Table 13A depicts the responses according to the sex of the respondents. More males (21.1%) compared to females (8.1%) knew HIV caused AIDS. More females (83.7%) than males (62.2%) did not know the cause of AIDS.

A significant relationship was found between "knowledge of the cause of HIV/AIDS" and "sex", χ^2 (3) = 12.025, p = .007. A post hoc test revealed that this was a weak relationship which accounted for 26% of the variance.

Table13A: ***Distribution of knowledge on the cause of AIDS according to the sex of the respondent.***

	Male		Female		Total	
Cause of AIDS	**No**	**%**	**No**	**%**	**No**	**%**
HIV	19	21.1	7	8.1	26	14.8
Germ	4	4.5	4	4.7	8	4.5
AIDS Virus	11	12.2	3	3.5	14	8.0
Don't Know	56	62.2	72	83.7	128	72.2
TOTAL	90	100.0	86	100.0	176	100.0

The responses according to the education level of the respondents is presented in Table 13B. The number of respondents educated to 9th standard or above that stated HIV was the cause of AIDS was (38.9%) compared to respondents educated between 1st to 5th standard (7.3%), no education (2.5%) and 6th to 8th standard (2.4%).

A significant relationship was found between "knowledge of the cause of HIV/AIDS" and "education level", χ^2 (9) = 38.155, p = .00002. A post hoc test revealed that this was a moderate relationship which accounted for 47% of the variance.

Table 13B: ***Distribution of knowledge on the cause of AIDS according to the education level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Cause	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
HIV	1	2.5	3	7.3	2	2.4	21	38.9
Germ	2	5.0	2	4.9	4	9.8	0	0.0
AIDS Virus	3	7.5	3	7.3	3	7.3	5	9.3
Don't Know	34	85.0	33	80.5	33	80.5	28	51.8
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

The distribution of responses according to the methods of transmission of HIV/AIDS is presented in Table 14A and 14B. Table 14A presents the responses according to the sex of the respondents. More males (67.8%) compared to females (39.5%) stated HIV/AIDS was transmitted by sexual intercourse. Males stated more methods of transmission in comparison to females. Sexual intercourse (54.0%) was the most stated method of transmission by all respondents followed by infected needles, blades and syringes (31.8%), blood transfusions (31.3%) and vertical transmission (mother to foetus) (8.5%). The number of responses indicating no knowledge of any methods of transmission of HIV/AIDS or stating incorrect methods of transmission was 40.3%.

Table 14A: ***Distribution of the methods of transmission of HIV/AIDS according to the sex of the respondent.***

	Male N=90		Female N=86		Total N=176	
Method of Transmission	**No**	**%**	**No**	**%**	**No**	**%**
Sexual Intercourse	61	67.8	34	39.5	95	54.0
Infected needles etc	35	38.9	21	24.4	56	31.8
Blood Transfusion	33	36.7	22	25.6	55	31.3
Vertical transmission	9	10.0	6	7.0	15	8.5
Dont Know/Incorrect	24	26.7	47	54.7	71	40.5

Table 14B presents the responses according to the education level of the respondents. Sexual intercourse was the most frequently stated method of transmission. The majority of respondents educated at 9th standard or above (81.5%) stated sexual intercourse transmitted HIV/AIDS followed by respondents educated between 6th to 8th standard (58.5%) and respondents with no education (33.3%). Responses of transmission by infected needles/blades and syringes, blood transfusion and vertical transmission (mother to foetus) also increased as the respondent's level of education increased.

Table 14B: ***Distribution of the methods of transmission of HIV/AIDS according to the education level of the respondent.***

	Nil-5th Std N=81		6-8th Std N=41		9th Std+ N=54		Total N=176	
Transmission	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Sexual Intercourse	27	33.3	24	58.5	44	81.5	95	54.0
Inf. Needles etc	7	8.6	13	31.7	36	66.7	56	31.8
Blood transfusion	16	19.8	11	26.8	28	51.9	55	31.3
Vertically	1	1.2	4	9.8	10	18.8	15	8.5
Dont Know/Incorrect	52	64.2	15	36.6	4	7.4	71	40.3

Table 15A and 15B present the misconception of HIV/AIDS being transmitted by shaking hands. Table 15A depicts the responses according to the sex of the respondent. More males (26.0%) compared to females (24.4%) stated HIV/AIDS could be transmitted by shaking hands. More males (50.0%) stated HIV/AIDS could not be transmitted by shaking hands compared to females (38.4%).

However, no significant relationship was found between "misconception of HIV/AIDS transmission by handshake" and gender", χ^2 (2) = 3.6999, p = .1572.

Table 15A: ***Distribution of the misconception that HIV/AIDS can be transmitted by shaking hands according to the sex of the respondent.***

	Male		Female		Total	
Transmitted by shaking hands	**No**	**%**	**No**	**%**	**No**	**%**
Yes	23	26.0	21	24.4	44	25.0
No	45	50.0	33	38.4	78	44.3
Don't Know	22	24.0	32	37.2	54	30.7
TOTAL	90	100.0	86	100.0	176	100.0

Table 15B presents the responses according to the education level of the respondents. The majority of respondents educated to 9th standard and above (68.1%) stated HIV/AIDS could not be transmitted by shaking hands followed by respondents educated between 6th to 8th standard (46.4%), no education (25.0%) and 1st to 5th standard (24.4%).

A significant relationship was found between "misconception of HIV/AIDS transmission by handshake" and "education level", χ^2 (6) = 39.773, p < .0001. A post hoc test revealed that this was a moderate relationship which accounted for 48% of the variance.

Table: 15B: ***Distribution of the misconception that HIV/AIDS can be transmitted by shaking hands according to education level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Transmitted by shaking hands	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	7	17.5	16	39.0	11	26.8	10	18.5
No	10	25.0	10	24.4	19	46.4	39	72.2
Don't Know	23	57.5	15	36.6	11	26.8	5	9.3
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

DIS-325 N97
05890

Table 16A and 16B show the distribution the misconception that HIV/AIDS can be transmitted by sharing cups, plates or clothing. Table 16A presents the responses according to the sex of the respondents. More males (37.0%) stated HIV/AIDS was transmitted by sharing utensils and clothing compared to females (33.7%). More males (43.0%) also stated it was not transmitted by sharing utensils and clothing compared to females (31.4%). The number of respondents that did not know if HIV/AIDS was transmitted by sharing utensils and clothing was 27.3%.

A significant relationship was found between "misconception of HIV/AIDS transmitted by cups etc" and "sex", χ^2 (2) = 6.121, p = .047. A post hoc test revealed that this was a weak relationship which accounted for 19% of the variance.

Table 16A ***Distribution of the misconception of HIV/AIDS being transmitted by sharing cups, plates or clothing according to the sex of the respondent.***

	Male		Female		Total	
Transmitted by cups, plates, etc	**No**	**%**	**No**	**%**	**No**	**%**
Yes	33	37.0	29	33.7	62	35.2
No	39	43.0	27	31.4	66	37.5
Don't Know	18	20.0	30	34.9	48	27.3
TOTAL	90	100.0	86	100.0	176	100.0

Table 16B presents the responses according to the education level of the respondents. The accuracy as to the transmission of HIV/AIDS by sharing utensils and clothing increased as the respondent's education level increased. The majority of respondents educated to 9th standard or above (61.1%) stated HIV/AIDS could not be transmitted through sharing utensils and clothing followed by respondents educated between 6th to 8th standard (31.7%), 1st to 5th standard (29.3%) and respondents with no education (20.0%).

A significant relationship was found between "misconception of HIV/AIDS transmission by cups etc" and "education level", χ^2 (6) = 44.881, p < .001. A post hoc test revealed that this was a moderate relationship which accounted for 51% of the variance.

Table: 16B: ***Distribution of transmission of HIV/AIDS by sharing cups, plates or clothing according to the education level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Transmitted by cups, plates, etc	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	12	30.0	17	41.4	16	39.0	17	31.5
No	8	20.0	12	29.3	13	31.7	33	61.1
Don't Know	20	50.0	12	29.3	12	29.3	4	7.4
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

The distribution of knowledge of the respondents on the curability of HIV/AIDS is depicted in Table 17A and 17B. Table 17A presents the responses according to the sex of the respondents. More males (64.4%) stated there was no cure for HIV/AIDS compared to females (48.8%). More females (36.1%) compared to males (17.8%) did not know if there was a cure for HIV/AIDS.

A significant relationship was found between "knowledge of the curability of HIV/AIDS" and "sex", χ^2 (2) = 7.753, p = .021. A post hoc test revealed that this was a weak relationship which accounted for 21% of the variance.

Table 17A: ***Distribution of knowledge on the curability of HIV/AIDS according to the sex of the respondent.***

	Male		Female		Total	
HIV/AIDS curable	**No**	**%**	**No**	**%**	**No**	**%**
Yes	16	17.8	13	15.1	29	16.5
No	58	64.4	42	48.8	100	56.8
Don't Know	16	17.8	31	36.1	47	26.7
TOTAL	90	100.0	86	100.0	176	100.0

Table 17B presents the responses according to the education level of the respondents. More respondents educated to 9th standard or above (81.5%) stated there was no cure for HIV/AIDS followed by respondents educated between 6th to 8th standard (58.5%), 1st to 5th standard (41.5%) and respondents with no education (37.5%). The number of respondents who did not know if HIV/AIDS is curable decreased with the increasing education level of the respondent. 45% of respondents with no education did not know if HIV/AIDS was curable compared to 36.5% educated between 1st to 5th standard, 6th to 8th standard (26.9%) and 9th standard and above (5.5%).

A significant relationship was found between "knowledge of curability of HIV/AIDS" and "educatin level", χ^2 (6) =26.787, p = .0002. A post hoc test revealed that this was a moderate relationship which accounted for 40% of the variance.

Table 17B: ***Distribution of knowledge on the curability of HIV/AIDS according to the education level of the respondent.***

	No educ		1-5th Std		6-8th Std		9th Std+	
Is HIV/AIDS curable	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	7	17.5	9	22.0	6	14.6	7	13.0
No	15	37.5	17	41.5	24	58.5	44	81.5
Don't Know	18	45.0	15	36.5	11	26.9	3	5.5
TOTAL	40	100.0	41	100.0	41	100.0	54	100.0

Table 18A and 18B present the distribution of knowledge of the respondents according to the method of detecting HIV/AIDS. Table 18A presents the responses according to the sex of the respondents. More males (58.9%) stated correctly a blood test or Elisa test is used to detect HIV/AIDS compared to females (50.0%). The number of respondents that stated correctly, a blood test or Elisa test is used to detect HIV/AIDS was 52.8%. Incorrect responses accounted for 60.8% of responses.

Table 18A: ***Distribution of knowledge on the methods of detection of HIV/AIDS according to the sex of the respondent.***

	Male		Female		Total	
Methods of Detection	**No**	**%**	**No**	**%**	**No**	**%**
Correct	53	58.9	43	50.0	96	54.5
Incorrect	49	54.4	58	67.4	107	60.8

Table 18B presents the methods of detection of HIV/AIDS according to the education level of the respondents. The number of respondents who stated a blood test or Elisa test was used to detect HIV/AIDS increased with the increasing educational level of the respondents. More respondents educated to 9th standard and above (72.2%) stated the correct test to detect HIV/AIDS followed by respondents educated between 6th to 8th standard (65.9%), 1st to 5th standard (43.9%) and respondents with no education (30.0%). The increased level of education of the respondents corresponded to a decrease in not knowing which test was used to detect HIV/AIDS. More respondents with no education (80.0%) incorrectly stated the test used to detect HIV/AIDS followed by respondents educated between 1st to 5th standard (73.2%), 6th to 8th standard (56.1%) and respondents educated to 9th standard and above (40.7%).

Table 18B: ***Distribution of knowledge on the methods of detection of HIV/AIDS according to education level of the respondent.***

	No educ N=40		1-5th Std N=41		6-8th Std N=41		9th Std+ N=54		Total	
Knowledge of method of detection	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Correct	12	30.0	18	43.9	27	65.9	39	72.2	96	54.5
Incorrect	32	80.0	30	73.2	23	56.1	22	40.7	107	60.8

Table 19 shows the distribution of responses concerning knowledge of the signs and symptoms of HIV/AIDS according to the sex of the respondents. More females (27.9%) stated weight loss as being a sign of HIV/AIDS compared to men (24.4%). More males (21.1%) stated fever was a sign of HIV/AIDS compared to females (11.6%). 26.1% of the total responses indicated weight loss as a sign of HIV/AIDS followed by fever (16.5%), skin diseases (8.0%), coughing (5.1%) and fatigue (4.5%). The number of responses indicating that respondents did not know any signs of HIV/AIDS was 62.5%.

Table 19: ***Distribution of knowledge according to the signs of HIV/AIDS stated according to the sex of the respondent.***

	Male N=90		Female N=86		Total N=176	
Signs of HIV/AIDS	**No**	**%**	**No**	**%**	**No**	**%**
Weight Loss	22	24.4	24	27.9	46	26.1
Diarrhoea	2	2.2	4	4.7	6	3.4
Fever	19	21.1	10	11.6	29	16.5
TB	1	1.1	0	0.0	1	0.6
Skin Diseases	9	10.0	5	5.8	14	8.0
Swollen Glands	1	1.1	3	3.5	4	2.3
Fatigue	2	2.2	6	7.0	8	4.5
Coughing	5	5.6	3	3.5	9	5.1
Loss of Appetite	2	2.2	2	2.3	4	2.3
Various Diseases	0	0.0	1	1.2	2	1.1
General Unhealthiness	0	0.0	1	1.2	1	0.6
Don't Know	55	61.1	55	64.0	110	62.5

The distribution of knowledge of the prevention of HIV/AIDS of the respondents is depicted in Table 20A and 20B. Table 20A presents the methods of prevention according to the sex of the respondent. More males than females stated no premarital sex, monogomy, condoms and screening blood as methods of prevention. No premarital sex (34.7%) was the most stated response of the total respondents, followed by monogomy (33.5%), sterile needles (14.2%) and condoms (11.9%).The number of responses indicating incorrect methods of preventing HIV/AIDS or did not know was 49.5%.

Table 20A: ***Distribution of knowledge on the methods of prevention of HIV/AIDS according to the sex of the respondent.***

	Male N=90		Female N=86		Total N=176	
Methods of Prevention	**No**	**%**	**No**	**%**	**No**	**%**
No premarital sex	38	42.2	23	26.7	61	34.7
Monogamy	35	38.9	24	27.9	59	33.5
Condoms	16	17.8	5	5.8	21	11.9
Sterile needles	16	17.8	5	10.5	21	14.2
Screen blood	2	2.2	0	0.0	2	1.1
Incorrect/Don't Know	35	38.7	53	61.7	87	49.5

Table 20B presents the methods of prevention according to the age of the respondent. Respondents aged between 20 and 29 years stated no premarital sex (42.9%), monogomy (38.6%), sterile needles (26.2%) and condoms (19.0%) as the methods of preventing HIV/AIDS. The respondents aged between 20 and 29 years stated more methods of prevention than other age groups.

Table 20B: ***Distribution of knowledge on the methods of prevention of HIV/AIDS according to the age of the respondent.***

(age groups...)	N=16 14-19		N=42 20-29		N=49 30-39		N=41 40-49		N=28 50+	
Methods of prevention	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
No premarital sex	5	31.3	18	42.9	20	40.8	13	31.7	5	17.9
Monogamy	4	25.0	16	38.1	10	20.4	16	39.0	5	17.9
Condoms	1	6.3	8	19.0	5	10.2	6	14.6	1	3.6
Sterile needles	3	18.8	11	26.2	5	10.2	5	12.2	1	3.6
Screen blood	0	0.0	1	2.4	1	2.0	0	0.0	0	0.0
Incorrect/DK	9	56.4	19	45.3	20	40.8	19	46.2	20	70.9

Table 21 presents the distribution of respondents according to the age at which HIV/AIDS education should begin. The majority of respondents (44.9%) stated HIV/AIDS education should begin between the ages of 11 and 19 years. The number of respondents that did not know at what age HIV/AIDS education should begin was 30.7%.

Table 21 : ***Distribution of respondents according to suggestions on the age HIV/AIDS education should begin.***

Age HIV/AIDS education should begin	No	%
Don't Know	54	30.7
5-10 yrs	30	17.0
11-19 yrs	79	44.9
20-29 yrs	13	7.4
TOTAL	176	100.00

The distribution of respondents, according to sex, as to the inclusion of condom education with HIV/AIDS education is depicted in Table 22. More males (60.0%) than females (36.0%) stated condom education should be included with HIV/AIDS education.

A significant relationship was found between "inclusion of condom education" and "sex", χ^2 (2) = 12.826, p = .0016. A post hoc test revealed that this was a weak relationship which accounted for 27% of the variance.

The number of respondents that stated condom education should be included in HIV/AIDS education was 48.3% compared to 12.5% of respondents who stated that condom education should not be included and 39.2% of respondents who did not know whether condom education should be included.

Table 22 : ***Distribution of respondents according to the inclusion of condom education in HIV/AIDS education according to the sex of the respondent.***

	Male		Female		Total	
Condom Education	No	%	No	%	No	%
Yes	54	60.0	31	36.0	85	48.3
No	12	13.3	10	11.6	22	12.5
Don't Know	24	26.7	45	52.4	69	39.2
TOTAL	90	100.0	86	100.0	176	100.0

Table 23 depicts the distribution responses about the best person to educate others about HIV/AIDS according to the sex of the respondent. More males stated social workers (20.0%) and teachers (17.8%) are the best persons to educate others on HIV/AIDS compared to females who stated teachers (14.0%) and social workers (7.0%). More females (47.7%) stated doctors than males (46.7%). The total number of respondents who stated doctors as the best person to educate others about HIV/AIDS was 47.2% followed by teachers (15.9%), social workers (13.6%) and RUHSA (5.1%).

Table 23 : ***Distribution of the best person to educate others on HIV/AIDS according to the sex of the respondent.***

	Male N=90		Female N=86		Total N=176(f=217)	
Best person to educate others on HIV/AIDS	**No**	**%**	**No**	**%**	**No**	**%**
Teacher	16	17.8	12	14.0	28	15.9
Parents	1	1.1	5	5.8	6	3.4
Doctors	42	46.7	41	47.7	83	47.2
Nurse	2	2.2	4	4.7	6	3.4
Social workers	18	20.0	6	7.0	24	13.6
RUHSA	5	5.6	4	4.7	9	5.1
Adults	3	3.1	2	2.3	5	2.8
Television	1	1.1	0	0.0	1	0.6
Cinema	6	6.7	2	2.3	8	4.5
Knowledgeable person	3	3.3	4	4.7	7	4.0
Politicians	0	0.0	1	1.2	1	0.6
Village leaders	2	2.2	2	2.3	4	2.3
Voluntary agencies	1	1.1	0	0.0	1	0.6
Don't know	12	13.3	22	25.6	34	19.3

Table 24 shows the distribution of responses according to the reasons stated for sex before marriage. Pleasure (27.3%) was the most stated reason for sex before marriage followed by puberty (12.3%), family upbringing (8.0%) and the influence of cinema and television (6.8%). The number of respondents who did not know a reason for sex before marriage was 43.8%.

Table 24: ***Distribution of respondents on the reasons for sex before marriage.***

Reasons for sex before marriage	**No**	**%**
Puberty	22	12.5
Pleasure	48	27.3
Family Upbringing	14	8.0
Curiosity	2	1.1
Peer influence	4	2.3
Bad habits	4	2.3
Love/infatuation	4	2.3
Cinema/television	12	6.8
Delayed marriage	2	1.1
Environmental/econ'ic issues	4	2.3
Nature	1	0.6
Moral values	4	2.3
Ignorance	2	1.1
Don't know	77	43.8

The reasons for sex outside of marriage according to the sex of the respondent are presented in Table 25. More males (25.6%) than females (11.6%) stated conflict with spouse as the reason for sex outside of marriage. Similarly more males (15.6%) than females (12.8%) stated dissatisfaction with spouse as the reason for sex outside of marriage. More males (20.0%) than females (12.8%) stated pleasure was the reason for sex outside of marriage. More females (8.1%) than males (2.2%) stated the inability to control the spouse was the reason for sex outside of marriage. More females (38.1%) than males (38.9%) did not know the reason for sex outside of marriage.

Table 25: ***Distribution of reasons for sex outside of marriage according to the sex of the respondent.***

	Male N=90		Female N=86		Total N=176	
Reasons for sex outside of marriage	**No**	**%**	**No**	**%**	**No**	**%**
Conflict	23	25.6	10	11.6	33	18.8
Dissatisfaction	14	15.6	11	12.8	25	14.2
Pleasure	18	20.0	11	12.8	29	16.5
Natural	1	1.1	2	2.3	3	1.7
Arranged marriage	0	0.0	1	1.2	1	0.6
Alcohol	2	2.2	1	1.2	3	1.7
Environmental/Economic	3	3.3	0	0.0	3	1.7
Religious	0	0.0	1	1.2	1	0.6
Ignorance	0	0.0	1	1.2	1	0.6
Unable to control spouse	2	2.2	7	8.1	9	5.1
Previous relationship	1	1.1	0	0.0	1	0.6
Don't Know	35	38.9	50	58.1	85	48.3

Table 26 presents the distribution of respondents according to the number of persons having sex before marriage in the respondent's village, according to the village of residency of the respondent. The total number of respondents who did not know the number of persons having sex before marriage was 63.1%. More respondents from the village of Latteri (43.6%) stated "people were having sex before marriage" compared to Pallathur (32.9%) and Pillandipattu (24.7%). Pillandipattu was the only village where some respondents (10.5%) stated "no persons were engaging in sex before marriage".

A significant relationship was found between "having sex before marriage" and "village", χ^2 (30) = 45.4437, p = .035. A post hoc test revealed that this was a moderate relationship which accounted for 51% of the variance.

Table 26: ***Distribution of respondents according to the number of persons having sex before marriage in the village, according to the village of residency of the respondent.***

	Pallathur		Latteri		Pillandipattu		TOTAL	
No of persons	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0	0	0.0	0	0.0	6	10.5	6	3.4
2	1	1.6	1	1.8	0	0.0	2	1.1
5	0	0.0	0	0.0	1	1.8	1	0.6
6	1	1.6	0	0.0	0	0	1	0.6
8	0	0.0	0	0.0	1	1.8	1	0.6
10	5	7.8	5	9.1	2	3.5	12	6.8
13	1	1.6	0	0.0	0	0.0	1	0.6
15	0	0.0	0	0.0	3	5.2	3	1.7
20	6	9.4	5	9.1	2	3.5	13	7.4
25	4	6.2	5	9.1	0	0.0	9	5.1
30	2	3.1	1	1.8	1	1.8	4	2.3
50	1	1.6	5	9.1	2	3.5	8	4.5
60	0	0.0	1	1.8	0	0.0	1	0.6
90	0	0.0	0	0.0	1	1.8	1	0.6
98	0	0.0	1	1.8	1	1.8	2	1.1
Don't know	43	67.1	31	56.4	37	64.8	111	63.1
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

The distribution of respondents according to the number of married persons having sex with someone other than their spouse, according to the village of residency of the respondent, is presented in Table 27. The majority of respondents from the villages did not know the numbers of people engaging in sex outside of marriage. The majority of respondents from the village of Pillandipattu (69.3%) did not know the number of persons engaging in sex outside of marriage followed by Latteri (67.4%) and Pallathur (67.1%).

However, no significant relationship was found between "extra marital sex" and "village", χ^2 (24) = 30.717, p = .1621.

Table 27: ***Distribution of respondents according to the number of married persons in the village having sex with someone other than their spouse, according to the village of residency of the respondent.***

	Pallathur		Latteri		Pillandipattu		TOTAL	
No of persons	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0	1	1.6	1	1.8	7	12.3	9	5.1
2	1	1.6	0	0.0	0	0.0	1	0.6
3	0	0.0	1	1.8	0	0.0	1	0.6
5	5	7.7	3	5.5	0	0.0	8	4.5
6	0	0.0	1	1.8	0	0.0	1	0.6
10	6	9.4	6	10.9	1	1.8	13	7.4
20	3	4.7	1	1.8	3	5.3	7	4.0
25	1	1.6	1	1.8	1	1.8	3	1.7
30	2	3.1	0	0.0	0	0.0	2	1.1
40	1	1.6	0	0.0	0	0.0	1	0.6
50	1	1.6	2	3.6	2	3.5	5	2.8
60	0	0.0	2	3.6	1	1.8	3	1.7
Don't know	43	67.1	37	67.4	42	73.6	122	69.3
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

Table 28 depicts the distribution of respondents according to the village of residency, regarding the stated number of homosexuals in the village. The majority of respondents (96.6%) stated there were no homosexuals in the village. The number of respondents from Latteri who stated there were homosexuals in the village was 5.4%, compared to Pallathur (3.2%) and Pillandipattu (1.8%).

No significant relationship was found between "number of homosexuals in the village" and "village", χ^2 (10) = 7.995, p = .6293.

Table 28: ***Distribution of respondents according to the number of homosexuals in the village, according to the village of residency of the respondent.***

	Pallathur		Latteri		Pillandipattu		TOTAL	
No of homosexuals	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0	15	23.4	17	30.9	20	35.1	52	29.5
2	0	0.0	1	1.8	1	1.8	2	1.1
3	0	0.0	1	1.8	0	0.0	1	0.6
5	1	1.6	1	1.8	0	0.0	2	1.1
40	1	1.6	0	0.0	0	0.0	1	0.6
Don't know	47	73.4	35	63.7	36	63.1	118	67.0
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

The distribution of respondents according to the village of residency of the respondent regarding the number of commercial sex workers in the village is depicted in Table 29. The majority of respondents stated there were either no sex workers in the village (28.4%) or the number of sex workers was not known (53.4%). Latteri (37.1%) had the highest number of respondents who stated sex workers were present in the village followed by Pallathur (11.1%) and Pillandipattu (7.1%).

A significant relationship was found between "number of commercial sex workers in village" and "village", χ^2 (26) = 42.966, p = .0195. A post hoc test revealed that this was a moderate relationship which accounted for 49% of the variance.

Table 29: ***Distribution of respondents according to the number of commercial sex workers in the village, dependent on the village of residency of the respondent.***

	Pallathur		Latteri		Pillandipattu		TOTAL	
No of commercial sex workers	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0	18	28.1	15	27.3	17	29.8	50	28.4
2	0	0.0	1	1.8	0	0.0	1	0.6
3	0	0.0	1	1.8	0	0.0	1	0.6
4	1	1.6	0	0.0	0	0.0	1	0.6
5	1	1.6	2	2.6	1	1.8	4	2.3
10	1	1.6	5	9.2	3	5.3	9	5.1
15	2	3.1	0	0.0	0	0.0	2	1.1
20	0	0.0	6	10.9	0	0.0	6	3.4
25	0	0.0	2	3.6	0	0.0	2	1.1
30	1	1.6	1	1.8	0	0.0	2	1.1
50	1	1.6	1	1.8	0	0.0	2	1.1
65	0	0.0	1	1.8	0	0.0	1	0.6
98	0	0.0	1	1.8	0	0.0	1	0.6
Don't know	39	50.8	19	34.6	36	63.1	94	53.4
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

Table 30 presents the distribution of respondents according to the number of commercial sex workers who go to other towns or villages to practice, according to the village of residency of the respondent. There was a trend of more respondents from Latteri (29.1%) stating commercial sex workers went to other villages or towns to practice followed by Pallathur (8.0%) and Pillandipattu (3.5%).

However, no significant relationship was found between these variable, χ^2 (24) = 36.168, p = .0529.

Table 30: ***Distribution of respondents according to the number of commercial sex workers who go to other towns or villages to practice, according to the village of residency of the respondent.***

	Pallathur		Latteri		Pillandipattu		TOTAL	
No of commercial sex workers	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0	19	29.6	16	29.1	19	33.3	54	30.7
2	0	0.0	1	1.8	0	0.0	1	0.6
3	0	0.0	2	3.6	0	0.0	2	1.1
4	1	1.6	0	0.0	0	0.0	1	0.6
5	1	1.6	3	5.5	0	0.0	4	2.3
10	1	1.6	5	9.1	2	3.5	8	4.4
15	0	0.0	1	1.8	0	0.0	1	0.6
20	0	0.0	2	3.6	0	0.0	2	1.1
25	0	0.0	1	1.8	0	0.0	1	0.6
30	1	1.6	0	0.0	0	0.0	1	0.6
45	0	0.0	1	1.8	0	0.0	1	0.6
90	1	1.6	0	0.0	0	0.0	1	0.6
Don't know	40	62.4	23	41.9	36	63.2	99	56.3
TOTAL	64	100.0	55	100.0	57	100.0	176	100.0

The distribution of respondents who ask the doctor to use a sterile needle, according to the sex of the respondent, is presented in Table 31. More males (51.0%) in comparison to females (36.0%) ask the doctor to use a sterile needle. 43.8% of the total respondents asked for the doctor to use a sterile needle whilst 36.4% did not ask.

However, no significant relationship was found between "asking the doctor to use a sterile needle" and "sex", χ^2 (4) = 7.192, p = .126.

Table 31: ***Distribution of respondents, according to sex, who ask the doctor to use a sterile needle.***

	Male		Female		Total	
Asking for sterile needle use	**No**	**%**	**No**	**%**	**No**	**%**
Yes	46	51.0	31	36.0	77	43.8
No	25	27.8	39	45.3	64	36.4
Don't Know	14	15.6	13	15.1	27	15.3
Not Applicable	5	5.6	3	3.6	8	4.5
TOTAL	90	100.0	86	100.0	176	100.0

The distribution of respondents who take a sterile needle to the doctors according to the sex of the respondent is shown in Table 32. More males (46.7%) than females (27.9%) take a sterile needle to the doctors. Overall less of the total sample take sterile needles to the doctors (37.5%) compared to respondents who do not take sterile needles to the doctors (43.2%).

However, no significant relationship was found between "taking sterile needles to doctors" and "sex", χ^2 (3) = 7.401, p = .0602.

Table 32: ***Distribution of respondents according to sex, who take sterile needles to doctors.***

	Male		Female		Total	
Taking sterile needle to doctors	**No**	**%**	**No**	**%**	**No**	**%**
Yes	42	46.7	24	27.9	66	37.5
No	31	34.4	45	52.3	76	43.2
Don't Know	14	15.6	14	16.3	28	15.9
Not Applicable	3	3.3	3	3.5	6	3.4
TOTAL	90	100.0	86	100.0	176	100.0

Table 33 presents the distribution of respondents according to knowledge of the barber using a new blade, according to the sex of the respondent. More males (50.0%) were aware of the barber using a new blade compared to females (25.6%). Correspondingly more females (28.4%) did not know if the barber used a new blade compared to males (15.6%).

A significant relationship was found between "knowledge of barber's use of a new blade" and "sex", χ^2 (3) = 25.401, p = .00001. A post hoc test revealed that this was a moderate relationship which accounted for 38% of the variance.

Table 33: ***Distribution of respondents according to knowledge of the barber's using a new blade.***

	Male		Female		Total	
New blade used	**No**	**%**	**No**	**%**	**No**	**%**
Yes	45	50.0	22	25.6	67	38.1
No	29	32.2	17	19.8	46	26.1
Don't Know	14	15.6	36	41.9	50	28.4
Not Applicable	2	2.2	11	12.7	13	7.4
TOTAL	90	100.0	86	100.0	176	100.0

The distribution of respondents according to the perceived change in the level of improper sex in the last twelve months is depicted in Table 34. The number of respondents who stated the level of improper sex had increased was 21.0%, whilst 26.7% stated the level had decreased. The number of respondents who did not know the change in the level of improper sex was 43.8% and 8.5% stated the level had remained the same.

Table 34: ***Distribution of respondents according to the change in the level of improper sex in the last twelve months.***

Perceived change	**No**	**%**
Increased	37	21.0
Decreased	47	26.7
Remained the same	15	8.5
Don't know	77	43.8
TOTAL	176	100.0

Table 35 depicts the distribution of respondents according to whether condoms are 100% effective in preventing the transmission of HIV/AIDS. Condoms were stated to be 100% effective by 30.1% of the sample population whilst 24.4% of respondents stated condoms were not 100% effective and 45.5% of respondents did not know the effectiveness of condoms.

Table 35: ***Distribution of respondents according to whether condoms are 100% effective in preventing the transmission of HIV/AIDS.***

100% Effective	No	%
Yes	53	30.1
No	43	24.4
Don't know	80	45.5
TOTAL	176	100.0

Table 36 presents the distribution of respondents according to the availability of condoms in the village, according to the sex of the respondent. More males (36.7%) than females (16.3%) stated condoms were available in the village. Correspondingly 26.6% of males did not know if condoms were available in the village compared to 66.3% of females.

A significant relationship was found between "stating condoms were available" and "sex", χ^2 (2) = 27.7988, $p < .001$. A post hoc test revealed that this was a moderate relationship which accounted for 40% of the variance.

Table 36: ***Distribution of respondents according to whether condoms were available in the village.***

	Male		Female		Total	
Availability	No	%	No	%	No	%
Yes	33	36.7	14	16.3	47	26.7
No	33	36.7	15	17.4	48	27.3
Don't Know	24	26.6	57	66.3	81	46.0
TOTAL	90	100.0	86	100.0	176	100.0

Table 37 presents the distribution of respondents according to what should be done for a HIV/AIDS infected person. The majority of respondents (48.9%) stated a HIV/AIDS infected person should be hospitalised whilst 21.0% stated the person should stay at home and 14.2% stated the person should be isolated. The number of respondents who did not know what should be done for a HIV/AIDS infected person was 19.9%.

Table 37: ***Distribution of respondents according to what should be done for a HIV/AIDS infected person.***

N=176

What should be done	No	%
Don't know	35	19.9
Stay at home	37	21.0
Hospitalisation	86	48.9
Isolation	25	14.2
Care/respect	4	2.3
Give monetary support	1	0.6
Provide advice	1	0.6

The distribution of respondents according to suggestions for preventing HIV/AIDS is depicted in Table 38. Awareness and education (35.8%) was the most stated preventative measure followed by self control (19.3%), cure and doctors (8.0%), monogomy (6.3%) and censoring television and movies (6.3%). The number of respondents who did not state any suggestions for preventing HIV/AIDS was 35.8%.

Table 38: ***Distribution of respondents according to suggestions for preventing HIV/AIDS .***

(N=176)

Community Suggestions	No	%
Monogamy	11	6.3
Self control	34	19.3
Awareness/education	63	35.8
Use sterile needles etc	7	4.0
Cure/doctor	14	8.0
Condoms	2	1.1
Prayer	2	1.1
Cooperation of all	2	1.1
Adhere to traditional culture	2	1.1
No sex before marriage	3	1.7
Screen blood	1	0.6
Censor movie/television	11	6.3
Respect others	3	1.7
Don't know	63	35.8

15.5

DISCUSSION

The evaluation was implemented in KV Kuppam Block of the North Arcott Ambedkar District, Tamil Nadu, India, assessing the RUHSA implemented HIV/AIDS awareness programme in KV Kuppam Block. The RUHSA HIV/AIDS awareness programme commenced in 1996.

A total of 176 respondents from three villages were interviewed for the evaluation. The majority of the respondents were engaged in agricultural oriented employment. Most of the respondents were either uneducated or educated below 9th Standard. An important finding of the evaluation was that 75% of the sample population had heard of HIV/AIDS. Invariably the largest sources of HIV/AIDS information can be attributed to the mass media, specifically television (61.4%), radio (26.7%) and newspapers (14.8%). Apart from the mass media, RUHSA figured prominently in the respondent's acquisition of HIV/AIDS knowledge. 28.4% of the sample population had attended RUHSA's HIV/AIDS awareness programme which placed RUHSA as the second highest source of acquisition of HIV/AIDS knowledge of the respondent.

The high percentage of the population who had seen the RUHSA programme reinforces the role of non government organisations in combating HIV/AIDS.

> *"NGOs will play a major role in AIDS prevention and control in India. They have access to difficult-to-reach populations and many groups practicing risk behaviour (NACO, 1994: 64).*

The authors believe NGO's have the methods and resources to provide a more comprehensive and indepth understanding of HIV/AIDS within the community compared to television. Television generally only provides short advertisements on HIV/AIDS without providing a full understanding of the issues surrounding HIV/AIDS.

In comparison, findings from the RUHSA HIV/AIDS awareness base line study undertaken in 1996 found 63.1% of respondents had acquired HIV/AIDS information from the television followed by radio (58.4%) and newspaper (18.1%). Only 6.0% of the base line population had been exposed to knowledge on HIV/AIDS by RUHSA. Following the implementation of the RUHSA HIV/AIDS Awareness Programme in 1997 the number of the population who have been exposed to RUHSA's programme has increased to 28.4%. Strategic planning and implementation of the RUHSA programme has resulted in more of the population acquiring HIV/AIDS knowledge from RUHSA than prior to the HIV/AIDS programme.

The video presentation on HIV/AIDS was the most seen RUHSA programme with 17.0% of the respondents having attended the screening of the video. The second most attended RUHSA
intervention was the cultural programme. According to the respondents, the video was the best method of HIV/AIDS awareness programme with 10.8% of the sample population preferring the video. According to popularity the following methods were seen as useful, pamphlet, cultural programme and rally. Community education and awareness is seen as vital in tackling the HIV/AIDS epidemic. The community appears to understand the importance of education and awareness. Education and awareness was stated by 35.8% of the respondents as the first means of preventing HIV/AIDS.

The varied nature of the RUHSA programme, combined with the use of different media, appears to be beneficial. The diversity of the targeted group, including culture, gender and educational levels, means using differing methods of communication is critical in addressing the learning needs of the population

The information on HIV/AIDS obtained by the community appears to be shared. People fourteen years and above resided in 91.0% of the respondent's households. Respondents stated the majority of people aged fourteen years and above residing in the household (61.4%) knew of HIV/AIDS. RUHSA has encouraged the transfer of knowledge within the

community. Due to limited resources the communication of HIV/AIDS messages by programme attendees is seen as a vital step in facilitating the knowledge process.

The knowledge of the respondents on issues regarding the mortality, incidence and incurability of HIV/AIDS varied. The number of respondents that stated a person with HIV/AIDS would die was 54.0%. The RUHSA HIV/AIDS awareness base line survey found 79.2% of respondents stated HIV/AIDS was a fatal disease (1996). A similar study of University students in Baroda found only 38.2% of the respondents knew HIV/AIDS was fatal (Sinha, 1995). Similarly 16.5% of the sample population stated HIV/AIDS was curable compared to 14.8% of the RUHSA HIV/AIDS base line study (1996).

A similar study of University students in Baroda found 38.2% of the population thought HIV/AIDS was curable (Sinha, 1995). Given the contrast in the two study populations, one population largely uneducated and one university educated, it is a significant difference. The possibility exists that different methods of HIV/AIDS awareness may be more beneficial to different populations. In the current study there appears to be a correlation between the education level of the respondent and the overall HIV/AIDS knowledge. Increased levels of education led to increased knowledge of HIV/AIDS, including areas of transmission, prevention, incidence and fatality.

Differences also existed in the responses to knowledge orientated questions concerning HIV/AIDS. Overall males knew more about HIV/AIDS than females. Females also did not appear to attend the public education campaigns organised by RUHSA in the same numbers as males. It is believed different programmes need to be specifically targeted for women to address cultural and gender issues that effect discussing sensitive issues in a mixed gender environment. Furthermore it is believed females are less likely to attend the public education campaigns due to differing gender and social roles. Largely the role of the female in Inda is in the home environment and hence public campaigns will see more male attendees than females. Females must be equally educated about HIV/AIDS as an increasing number of females are becoming infected with HIV.

> *"At the beginning of the pandemic in developed countries, men were more exposed to HIV than women, primarily as the result of homosexual transmission or drug injecting. Now the difference in the numbers of men and women infected with HIV has gradually narrowed as heterosexual transmission has become more common" (NACO,1994:.7).*

Further implications of an increased number of women infected with HIV will be an increased number of HIV infected children, contracting HIV whilst a foetus.

> *"Women were more likely to remain victims of sex-related diseases because they did not have enough education regarding these illnesses, and were bogged down by cultural taboos. With the health of women receiving the lowest priority, very few females approached doctors on their own" (**The Hindu**, 15.4.1997:5).*

The current evaluation found 62.5% of the respondents knew HIV/AIDS was present in Tamil Nadu but only 22.7% knew it was present in the immediate environment in which the respondents reside, that being KV Kuppam Block. The RUHSA HIV/AIDS awareness programme base line survey found 32.2% of the population knew HIV/AIDS was present in Tamil Nadu (1996). The change in knowledge of the prevalence of HIV/AIDS has nearly doubled since 1996. The fact that HIV/AIDS is present in the respondents immediate environment is critical in educating the population. If the respondents believe HIV/AIDS is not present in KV Kuppam Block the authors believe awareness programmes will not have the same impact. The reality about the incidence of HIV/AIDS needs to be known by the community if appropriate action and behaviour change is to be implemented as a result of education.

The knowledge of the cause of AIDS was limited in the surveyed population. HIV was attributed as the cause of AIDS by 14.8% of the sample population, whilst 8.0% attributed AIDS to the AIDS virus. The RUHSA HIV/AIDS awareness base line study conducted in 1996 found 9.4% of the population attributed AIDS to HIV. An increase in the knowledge of the cause of AIDS has been achieved in the last twelve months although the reason for the

DIS-375
N97-
05830

increase cannot be directly attributed to RUHSA due to the interview schedule design. The study of Baroda University students found 50% of the respondents knew HIV caused AIDS. The differences in findings could be attributed to the respondents of the current evaluation having a limited comprehension of the English language. There is no Tamil equivalent for HIV and AIDS. The respondents of the current evaluation have limited comprehension of English which may have created difficulties in comprehension of HIV/AIDS and ability of recall.

The number of respondents who did not know any methods of transmission of HIV or incorrectly stated methods of transmission was 40.3%. Sexual intercourse (54.0%) was the most stated method of transmission. Sexual intercourse is responsible for the majority of HIV infection in India and accounts for 75.2% of all HIV infection (NACO, 1994). The authors believe the actual number of responses from the survey could be higher in terms of transmission by sexual intercourse, excepting the females resistance to talking about issues of a sensitive nature.

The RUHSA HIV/AIDS awareness base line survey found 55.0% of the surveyed population did not know any methods of transmission of HIV. The number of respondents from the base line study stating sexual intercourse as a method of transmitting HIV was 43.0%, indicating an increase in knowledge in the twelve month period since the implementation of the RUHSA HIV/AIDS awareness programme (1996).

Increased levels of knowledge were also found between the current study and the RUHSA base line study regarding methods of transmission. The number of respondents from the current study stating infected needles, syringes and blades as a method of transmission was 31.8% compared to 15.4% of respondents from the RUHSA base line survey. Similarly the current study found 31.3% of the population stated blood transfusions as a method of transmission of HIV compared to 10.7% of the RUHSA base line study. Transmission by mother to foetus showed the biggest change. The current study found 8.5% of respondents stated vertical transmission as method of transmitting HIV compared to 0.3% of respondents of the RUHSA base line study (1996).

Infected needles, syringes and blades were stated by 31.8% of the current sample population as being a method that transmits HIV. Not all doctors in India use sterile needles and syringes. Furthermore not all people can afford to buy sterile needles and syringes. Implications concerning the lack of knowledge about the transmission of HIV through needles, syringes and blades are serious. Only 43.8% of the sample population asked the doctor to use a sterile needle and only 37.5% of the sample population take a sterile needle or syringe when visiting the doctor. Further compounding the problem is a wide spread belief in the area that injections are more effective in curing ailments than other medication. The result is a preference among the population for injections rather than alternative medications.

Similarly only 38.1% of the surveyed population stated the barber uses a new blade. One barber interviewed for the evaluation report stated he only uses a new blade if the customer specifically asks for a clean blade.

The limited number of respondents knowing HIV can be transmitted via blood transfusions and blood products could have serious consequences. Blood transfusions account for 12.0% of HIV/AIDS cases in India making transfusions the second highest method of HIV transmission in India (NACO, 1994). In India 75% of blood banks are licensed whilst 25% are unlicensed (NACO, 1994).Strategies are being implemented at a national level to ensure the screening of blood and blood products. The unscrupulous practice undertaken by some blood collectors of seeking persons economically disadvantaged to donate blood poses serious problems. Unscrupulous blood collectors often approach high risk groups, including prostitutes and intravenous drug users, who are needing money, to donate blood.

A similar study of university students in Baroda found a much higher knowledge of the risk factors for transmitting HIV/AIDS (Sinha, 1995). The implications of the two findings suggests educational level plays an important role in the acquisition of knowledge and understanding of the complicated concepts of HIV/AIDS. It is suggested that the rural nature of the KV Kuppam Block impacts on the population's access to HIV/AIDS information, as

does the literacy level and educational level. The above suggestions indicate a multi media strategy is vital to meet the diversity of needs of the population of KV Kuppam Block. The RUHSA programme operates using a wide diversity of educational mediums and it is believed the RUHSA programme facilitates an understanding of HIV/AIDS in the community.

Similar differences were found in the awareness of the no risk factors surrounding the transmission of HIV/AIDS. HIV was believed to be transmitted by shaking hands by 25.0% of the sample population whilst 35.2% stated HIV could be transmitted by sharing cups, plates and clothing. The misconceptions of the surveyed population can have serious consequences when promoting the rights and dignity of HIV/AIDS infected people as well as facilitating a positive community attitude. Misconceptions that HIV is transmitted by simple, everyday activitites may create negative attitudes within the community towards HIV/AIDS infected persons.

The current study found 54.5% of the sample population knew a blood test or Elisa test was used to detect HIV/AIDS. In comparison the RUHSA HIV/AIDS awareness base line study found 33.2% of respondents knew a blood test or Elisa test was used to detect HIV/AIDS. There has been an increase in knowledge within the last twelve months regarding the test used to detect HIV/AIDS. The majority of the current study sample stated a HIV/AIDS infected person should be hospitalised (48.9%), stay at home (21.0%) or be isolated (14.2%). In comparison the RUHSA HIV/AIDS awareness base line study found the most common suggestions for treating a HIV/AIDS infected in the community were hospital treatment (21.1%), respect (12.8%), isolation within the village (7.7%) and isolation in hospital (4.7%) (1996).

It is evident prejudices and misconceptions still exist in the community and intense and strategic programmes need to be implemented to tackle the problems of ostracism and discrimination. Such ostracism and discrimination will effect home based care of the HIV/AIDS infected person. Ostracism and discrimination is not only an issue for the community.

> *"The fears of health care and community workers need to be allayed with clear information and education" (NACO, 1994:99).*

The responses on the two studies indicate the community views HIV/AIDS as primarily a health issue and does not fully understand the broader social, economic and political implications

Misconceptions about the transmission of HIV may also be compounded by the methods of transmission of tuberculosis which is prevalent in KV Kuppam Block. Tuberculosis is transmitted more easily than HIV and the community have an awareness of tuberculosis. RUHSA has continued to promote an understanding of the no risk factors of HIV transmission combined with promoting positive community attitudes to HIV/AIDS infected persons. Clearly misconceptions still exist. WHO states "entire populations must learn what does and does not spread HIV infection" (1988:3). The importance of not only educating about methods of transmission but also the no risk factors is a critical component of HIV/AIDS education.

The understanding of the respondents concerning the signs and symptoms of HIV/AIDS has increased significantly from the baseline data. Weight loss (26.1%), fever (16.5%), skin diseases (8.0%) and coughing (5.1%) are the most widely known signs and symptoms of HIV/AIDS in the current study. The RUHSA HIV/AIDS awareness base line study found weight loss (12.1%), chronic fever (7.0%) and chronic diarrhoea (2.7%) were the only signs and symptoms of HIV/AIDS stated by the respondents. It appears RUHSA has contributed to raising the awareness of the population regarding the signs and symptoms of HIV/AIDS although 62.5% of the respondents did not know any of the signs of HIV/AIDS. The base line study conducted in 1996 by RUHSA found 80.9% of the sample population did not know any sign or symptom of HIV/AIDS. Surprisingly few respondents stated tuberculosis to be a sign of HIV. **The Hindu** (4.5.97) stated as many as 50% of AIDS sufferers also have tuberculosis.

Similarly the knowledge of respondents concerning methods of prevention of HIV/AIDS has increased in comparison to the base line population. The current study found 49.5% of the respondents did not know any methods of prevention or stated incorrect methods compared to 61.7% of the base line survey population. The most known prevention methods in the current study were abstaining from sex before marriage (34.7%), monogomy (33.5%), sterile needles, blades and syringes(14.2%), condom use (11.9%) and screening blood (1.1%). In comparison to the RUHSA HIV/AIDS awareness base line study all methods of prevention have increased excepting screening blood. The most stated methods of prevention of HIV/AIDS in the base line survey were abstaining from sex before marriage (20.8%), monogomy (19.5%), sterile needles, blades and syringes (7.7%), screening blood (6.4%) and condom use (4.0%) (RUHSA, 1996).

The high knowledge of factors concerning the prevention of the sexual transmission of HIV/AIDS is directly related to the high knowledge of HIV/AIDS being transmitted by sexual intercourse. As knowledge concerning alternative methods of transmission was low it can be expected the knowledge on the prevention of HIV/AIDS by blood transfusions, mother to foetus and infected needles, syringes and blades would be correspondingly low. The importance of promoting methods of prevention of the transmission of HIV/AIDS is critical in promoting behaviour change.

> *"Various studies have shown that the spread may really level off or even decline as a result of behavioural changes. Reduction of the number of sexual partners and correct use of condoms during sexual intercourse have been proven to prevent HIV infection" (NACO, 1994:5).*

The majority of respondents believed HIV/AIDS education should begin whilst people are still of school attending age. RUHSA has implemented HIV/AIDS education programmes aimed at both students and teachers. The inter relationship between primary health care systems and educational systems has clearly been stated by WHO which claims

> *"formal organisations representing primary health care and education systems must take the lead in such programmes and be joined and supported by organisations, both large and small, across the entire spectrum of society" (1988:5).*

Unfortunately not all young people have the opportunity to attend school so provisions have been made by RUHSA to include such young people in general community education and also in targeted RUHSA training programmes, including vocational training programmes. RUHSA has also successfully implemented youth clubs and knowledge on HIV/AIDS is imparted to youth club members with a message to communicate the knowledge to community members.

The importance of educating young people cannot be underestimated. The high risk age group for contracting HIV/AIDS for both males and females is between the ages of 15 - 40 years and "at least half of all HIV infections to date worldwide have occurred in youth between 15 and 24 years of age" (NACO, 1994:111). HIV/AIDS education and sex education should ideally be implemented before young people become sexually active to be most successful.

> *"a survey of 35 studies from all parts of the world on the effect of sex education in schools, conducted by WHO, reveals that: sex education led to either a delay in starting sexual activity, or a decrease in activity sex education increased the adoption of safer sexual practices in those sexually active access to counselling and contraceptive services did not encourage earlier or increased sexual activity" (NACO, 1994:111).*

Not surprisingly teachers figured second highest in regards to the best person to educate others on HIV/AIDS. The most suitable person to educate on HIV/AIDS was a doctor. Social workers were seen as the third best person. The population of KV Kuppam Block identify social workers as any community worker, including Rural Community Officers, Family Care Volunteers and Health Aides. It is not surprising, given the medical nature of HIV/AIDS, that doctors figured prominently as the best person to educate others on HIV/AIDS

RUHSA utilises doctors as guest speakers in the HIV/AIDS awareness programme. The authors believe it is more important the community of KV Kuppam Block receive accurate and understandable knowledge pertaining to HIV/AIDS rather than who delivers the information. Furthermore staffing constraints do not always allow for a doctor to attend community education programmes. RUHSA figured as the fourth most appropriate source to educate others about HIV/AIDS. The author believes the figure could be higher as RUHSA is also composed of doctors and social workers. When the respondents stated doctors and social workers some may have meant RUHSA doctors and social workers/community workers.

Given the increased awareness of transmission of HIV/AIDS by sexual intercourse and prevention by condom usage it is not surprising that 48.3% of the respondents stated HIV/AIDS education should include education about condoms. Condom education could be included in sex education programmes and HIV/AIDS awareness programmes.

> *"An essential aspect to be promoted is the use of condoms ...Care should be taken that the promotion of condoms should not outrun the capacity of the health care system to provide them[a] condoms should not be promoted and expectations raised unless there is a system for supplying them and appropriate education and information about their purpose and use" (WHO, 1988).*

Condom education should also be sensitive to gender and cultural issues

The availability of condoms is an important factor. Condoms were not available in the village as stated by 27.3% of the sample population whilst 26.7% stated condoms were available in the village. The RUHSA HIV/AIDS awareness base line study found 64.8% of respondents stated condoms were not available in the village whilst 12.4% of the respondents stated condoms were available (1996). Additionally some condoms are of an inferior quality and education should also recommended using quality condoms, preferably with a spermicide. Condom information should not be misleading. Condoms were believed to be 100% effective against the transmission of HIV/AIDS by 30.1% of the surveyed population. The RUHSA HIV/AIDS awareness base line survey found 39.9% of the population stated condoms prevent HIV/AIDS whilst 54.7% did not know if condoms prevent HIV/AIDS. The authors believe the inaccuracy about condoms being 100% effective in the prevention of the transmission of HIV/AIDS may have been gained by the promotion of condoms by the mass media, particularly television.

Overall the HIV/AIDS awareness programme implemented by RUHSA in KV Kuppam Block has been successful. The programme has taken into account the varying needs of the client population and the different social factors that constitute the population. Attempts have been made to address gender and educational inequalities within the programme design and implementation. Additional targeting of women and specialised programmes for women still need to be further developed. Significant changes within the population of KV Kuppam Block in terms of knowledge acquisition have occurred since the implementation of the programme. RUHSA has reached many members of the community and will continue to be a valuable source of health education and awareness to the people of KV Kuppam Block.

RECOMMENDATIONS

1. Continue to enlist and train volunteers who can be utilised to target groups not generally covered by the typical RUHSA programme. Particular groups needing attention are women and isolated and difficult to access members of the population.
2. To systematically use techniques of repeated visits to villages and target different locations within villages to access the maximum number of the village population. The authors believe that an increase in the number of HIV/AIDS awareness programmes will result in an increase in the number of people being aware of the issues surrounding HIV/AIDS. Targeting different locations within the same village will also increase the exposure of the people to the HIV/AIDS awareness programmes. The authors found some villages spread over a large distance thus inhibiting some people from having a knowledge of the programme occurring and therefore not being able to witness the programme. A number of people, particularly, women did not appear to venture far from their own household. An increase in the number of programmes within the same village would increase the access of disadvantaged members of the community attending the programme, particularly women, the aged or infirmed and the people living in the removed colonies. Finally repetitive visits to villages will facilitate in reaching members of the village who did not attend previous programmes
3. Attendees at programmes should be encouraged to share information obtained from the RUHSA HIV/AIDS awareness programmes with others who did not attend the programme. The method of encouraging communication will facilitate in spreading the HIV/AIDS message. Apart from encouraging attendees to verbally communicate the HIV/AIDS message it may be beneficial to supply them with some pamphlets to distribute to friends and family.
4. Due to the belief held by the majority of respondents that doctors are the best persons to educate about HIV/AIDS, RUHSA needs to undertake a strategic programme to amend the belief. The authors believe it is of more importance the people of KV Kuppam Block receive accurate HIV/AIDS information rather than who is the conveyor of such information. Alternatively RUHSA could continue to utilise doctors as guest speakers.
5. The sensitive nature of topics concerning HIV/AIDS, sex, sexuality, condoms and high risk behaviours need to be changed. RUHSA could consider implementing a programme aimed at removing such barriers to facilitate the communication and awareness process.
6. Due to the misleading belief by some of the population that condoms are 100% effective in preventing the transmission of HIV, RUHSA should incorporate into the programme the advantages and disadvantages of condoms. Failure to do so will result in a continuation of the population's misconceptions and could ultimately place lives at risk. In conjunction with condom education RUHSA may chose to run a programme encouraging outlets in the village to supply quality condoms as it appears condoms are not available in all villages.
7. RUHSA could initiate communication with organisations promoting the use of condoms and clearly explain that the population of KV Kuppam Block hold mistaken beliefs about the effectiveness of condoms. Consultation could be initiated to facilitate the conveying of accurate and understandable information pertaining to condoms by external organisations.
8. RUHSA could incorporate special activities into the National HIV/AIDS Awareness Week. RUHSA may choose to implement a mass awareness campaign utilising maximum staff and volunteers to distribute information concerning HIV/AIDS in HIV/AIDS Week. Alternatively RUHSA may choose to run a poster competition in the villages in conjunction with HIV/AIDS Week to promote awareness. It is critical to remember, in the distribution of information, that many villagers are illiterate. Similar activities could be planned and implemented on International HIV/AIDS Awareness Day.

9. RUHSA needs to consider developing and implementing strategies to promote the HIV/AIDS awareness programme in the remote and isolated villages and communities e.g. where people live in field huts, removed colonies or abodes not accessible by vehicles.
10. RUHSA is one of the few means of spreading the HIV/AIDS message to the population who do not have access to he mass media. It is therefore imperative that RUHSA continue to promote HIV/AIDS awareness to the population of KV Kuppam Block in an intensive and systematic manner.
11. Implement alternative awareness campaigns aimed at colonies and areas where there is no electricity available which prevents the usage of the PA system and video demonstrations. Alternative campaigns also need to be designed for villages and household that do not have access for vehicles.
12. Community education should be intensified concerning the rights and dignity of the HIV/AIDS infected person and aimed at changing community attitudes. Many people still believe hospitalisation and isolation should be implemented for the HIV/AIDS infected person. Information about home based care and changing community attitudes needs to be clearly and distinctly stated in the HIV/AIDS awareness programme.
13. RUHSA needs to implement strategies to target the educationally disadvantaged members of the population of KV Kuppam Block. Alternative methods of awareness campaigns may need to be implemented to address the different learning needs of the proportion of the population who are educationally disadvantaged and those community members who are illiterate.
14. RUHSA should continue to establish and maintain links with the education systems in the KV Kuppam Block. Training of teachers and students should be continued. It is important young people are informed of HIV/AIDS before sexual activity begins.
15. RUHSA should promote the confidentiality of HIV/AIDS testing within the awareness programme so that members of the population who have been exposed to high risk factors may be encouraged to attend testing.
16. RUHSA could undertake further research into motivation toward high risk activities and develop and implement programmes aimed at creating behavioural change within the community.
17. The authors believe, given the nature of the client population of KV Kuppam Block, the programme objectives outlined in part A. to be unrealistic. The population is diverse and somewhat isolated and the authors believe it is not possible to reach 100% of the targeted population. Due to difficulty in accessing the population of KV Kuppam Block a realistic objective may be 85% - 95% of the targeted population.
18. RUHSA should be encouraged to apply for funding from numerous agencies to assist in increasing physical and human resources. Increased resources would facilitate in increasing the coverage and intensity of the HIV/AIDS awareness programme.
19. RUHSA should undertake a comprehensive evaluation in the second or final year of the HIV/AIDS awareness programme to evaluate objectives B to K of the HIV/AIDS awareness programme as the current evaluation only encompasses objective A.

LIMITATIONS

1. The unclarity of question five and six of the interview schedule created differences in the questioning of the subjects and the subsequent responses. It was unclear as to whether the number of occupants of a house aged over fourteen years included or excluded the respondent. As a result inconsistencies exist in question five and six.
2. The evaluation covers a small proportion of subjects in relation to the entire population. Factors impacting on the small sample size include time, travel and availability of interpreters.
3. There were no subjects taken from outside of KV Kuppam Block to enable a comparison to be made with an area that does not have a HIV/AIDS awareness programme implemented by RUHSA.
4. The nature of the questions in the interview schedule does not allow for accurate representation of the actual knowledge obtained from RUHSA but rather only the means by which the knowledge was obtained. The above limitation makes it difficult to accurately ascertain what knowledge is attributable to RUHSA and what knowledge is attributable to alternative methods of HIV/AIDS awareness
5. The sensitive nature of the questions, coupled with the fact that the interviewers were from outside the KV Kuppam Block (being from either Australia or Tiruchipalli) limited the accuracy and comprehensiveness of the responses of the subjects. Additionally the gender of the interviewers would have impacted on responses, particularly when the respondents were female, whilst the interviewers were male.
6. Due to the comprehensive nature of the HIV/AIDS awareness programme objectives, the evaluation has focussed primarily on the objectives contained in part a due to constraints of time. The above limitation has meant that objectives B to K inclusive, have not been evaluated in the current evaluation.
7. It was not possible to locate all the initially selected subjects due to absences from the household or village. When it was not possible to locate the systematically selected subject it was agreed by the relevant parties to firstly interview the preceding subject and failing that the successive subject would be interviewed.
8. As a result of some of the initially selected sample being absent from the household due to employment, training or educational commitments, the evaluation may not accurately reflect the employed or student population. Furthermore the interviews were conducted between 8am and 6pm when a proportion of the population may have been absent from the household due to the nature of the employment or at educational institutions.

REFERENCES

National AIDS Control Organisation. National AIDS Control Programme India: Country Scenario an Update . 1994.

RUHSA Department, Christian Medical College and Hospital. Profile of KV Kuppam Block . RUHSA, 1992.

RUHSA Department, Christian Medical College and Hospital. HIV/AIDS Awareness Programme Outline . RUHSA, 1995

RUHSA Department, Christian Medical College and Hospital. HIV/AIDS Awareness Programme Base Line Study . RUHSA, 1996.

Sinha, S. AIDS Awareness . Anmol Publications, New Delhi, 1995.

The Hindu, Regional, Tuesday, April 15, 1997. P.5.

The Hindu, Regional, Sunday, April 27, 1997

World Health Organisation. Guidelines For The Development Of a National AIDS Prevention And Control Programme . WHO, Geneva, 1988.

APPENDIX

RUHSA HIV/AIDS AWARENESS PROGRAMME EVALUATION

INTERVIEW SCHEDULE

FI Number:

Name:

Sex: Age:

Education level attained:

Occupation:

Caste:

Roof type of house: Thatched Tiled Terraced

Address:

1. Have you heard about HIV/AIDS?

YES NO DON'T KNOW

2. How did you hear about HIV/AIDS?

1. RADIO 2. TELEVISION 3. NEWSPAPER
4. SCHOOL 5. BOOKS 6. POSTERS
7. RUHSA 8. FAMILY 9. FRIENDS
10. OTHER _____

3. Was RUHSA involved in your HIV/AIDS education?

YES NO DON'T KNOW

If yes, in what ways?

1. EXHIBITION 2. VIDEO 3. PUPPET SHOW 4. PAMPHLET
5. BOOKLETS 6. RALLY 7. AUDIO TAPE 8. FCV
9. PUBLIC MEETING 10. DOCTOR 11. NURSE 12. RCO
13. BARBER 14. ADOLESCENT GIRLS GROUP
15. CULTURAL PROGRAMME 16. OTHER_____

4. What method of HIV/AIDS education from RUHSA was best for you?

1. EXHIBITION 2. VIDEO 3. PUPPET SHOW 4. PAMPHLET
5. BOOKLETS 6. RALLY 7. AUDIO TAPE 8. FCV
9. PUBLIC MEETING 10. DOCTOR 11. NURSE 12. RCO
13. BARBER 14. ADOLESCENT GIRLS GROUP
15. CULTURAL PROGRAMME 16. OTHER _____

5. How many people aged fourteen years and over live in your house?

NUMBER_____
OTHER_____

6. How many of the people aged over fourteen years in your house know about HIV/AIDS?

NUMBER_____
OTHER_____

7. Will a person with HIV/AIDS die?

YES NO DON'T KNOW

8. Is HIV/AIDS present in Tamil Nadu?

YES NO DON'T KNOW

9. Is HIV/AIDS present in KV Kuppam Block?

YES NO DON'T KNOW

10. What is the name of the virus that causes AIDS?

HIV GERM AIDS VIRUS DON'T KNOW

OTHER_____

11. How is HIV/AIDS spread?

1. SEXUAL INTERCOURSE
2. INFECTED NEEDLES, SYRINGES AND BLADES
3. BLOOD TRANSFUSION & BLOOD PRODUCTS
4. PERINATAL TRANSMISSION
5. DON'T KNOW
6. OTHER_____

12. Is HIV/AIDS spread by shaking hands?

YES NO DON'T KNOW

13. Is HIV/AIDS spread by sharing cups, plates and clothing?

YES NO DON'T KNOW

14. Is there a cure for HIV/AIDS?

YES NO DON'T KNOW

15. What test is used to find out if a person has HIV/AIDS?

1. BLOOD 2. ELISA 3. URINE 4. FAECES
5. DON'T KNOW 6. OTHER_____

16. What are some of the signs of HIV/AIDS?

1. WEIGHT LOSS 2. DIARRHOEA 3. FEVER 4. TB
5. CANDIDA INFECTION 6. SKIN DISEASES 7. PNEUMONIA
8. SWOLLEN GLANDS 9. FATIGUE 10. COUGHING
11. HERPES 12. DON'T KNOW 13. OTHER_____

17. How can HIV/AIDS be prevented?

1. NO SEX BEFORE MARRIAGE 2. MONOGOMY 3. CONDOMS
4. STERILE SYRINGES, NEEDLES & BLADES 5. SCREENING BLOOD
6. COMMUNITY EDUCATION 7. DON'T KNOW
8. OTHER_____

18. At what age should HIV/AIDS education begin?

AGE_____
DON'T KNOW

19. Should HIV/AIDS education include education about condoms?

YES NO DON'T KNOW

20. Who is the best person to educate others about HIV/AIDS?

1. TEACHER 2. PARENTS 3. DOCTOR 4. NURSE
5. SOCIAL WORKER 6. FCV 7. RCO 8. HEALTH AIDE
9. DON'T KNOW 10. OTHER_____

21. Why do you think young people have sex before marriage?

22. Why do you think people have sex outside of marriage?

23. How many people in your village are having sex with someone other than their spouse?

NUMBER_____
DON'T KNOW

24. How many married people in your village are having sex with someone other than their husband or wife?

NUMBER_____
DON'T KNOW

25. How many homosexuals are in your village?

NUMBER_____
DON'T KNOW

26. How many commercial sex workers are in your village?

NUMBER_____
DON'T KNOW

27. How many of these go to other towns to work?

NUMBER_____
DON'T KNOW

28. Do you ask your doctor and nurse if the needle or they are using is sterilised?

YES NO DON'T KNOW

29. Do you take sterile syringes and needles to your doctor or nurse?

YES NO DON'T KNOW

30. Does your barber use a new blade?

YES NO DON'T KNOW

31. Do you think improper sex in your village has:

1. INCREASED 2. DECREASED 3. REMAINED THE SAME
in the last year?
4. DON'T KNOW

32. Are condoms 100% effective in preventing the transmission of HIV/AIDS?

YES NO DON'T KNOW

33. Are condoms available in your village?

YES NO DON'T KNOW

34. What should be done for a person suffering from HIV/AIDS?

1. STAY AT HOME
2. HOSPITALISATION
3. ISOLATION
4. LEAVE THE VILLAGE
5. DON'T KNOW
6. OTHER_____

35. What is your suggestion to stop HIV/AIDS in the community?

RUHSA DEPARTMENT, CMCH, AIDS AWARENESS PROGRAMME

PROGRAMME INTENSITY TABLE

CENTRE **METHODS USED**

	Exhibition	General Group Ed	High Risk Group Ed	Mobile PA System	Indiv Ed	Rally	Public Mtg	Video Show	Puppet Show	Cult'al Prog
Labba Krishapuram	*	**		****		*	**	***		
Melmoil & Alangeri	**	**		****			****	***		
Shozhamur	*	*		****		*	**	***		*
KV Kuppam	**	***		*			**	***		***
Veppaneri	**	***		**	**		****		***	****
Panamadangi	*			***		****	***	***		
Kangkuppam	**	*	***	****		****	***	****		
Thirumani	*		***	***	*		*	***		
AN Pudur/Keel Pudur & AK Pudur	**			****	*	***	*	**		
Kalambattu	***	**	*	****	**	****	****	****		
Pallathur/ Maliyapattu	**	**		****			****	****		
Vizhunthakal	**			***			**	**		
Neelakanda-palayam & Puram	**	***	***	***				****	****	
Ramapuram	**	***	***	***			***	***		
Annangudi	*	***	*	***			****	****	****	
Perumangkuppam	**		***	***			***	***		
Kasvasampattu MV	**			***			***	***		
Senji	**	***		***			****	***		
Senji Krishnapuram	***	***		**			***	***	****	

Veppur	**	*		***	*		****	****		
Netteri	***	***		***			***	***		
Keel Alathur	****			****	*		**	**		
Senj Venkatapuram	***			****	*		***	***		
Nagal Chinna Nagal (colony)				***			***	***	****	
Vaduganthangal	**	***		****			**	**		
Kilmutukur	**			****			***	***		
Pillandipattu				****			****	***		
Thondanthulasi & Arumbakkam	***			***			***	***		
Nagal & Chinna Nagal (main vil.)	**	*		***			****	***	****	
Sethuvandai	**			***			***	***	****	
Chennangkuppam	**	**		**			****	****		
Machanur	****	**		***			****	****	****	
Pasamathur Colony	**	**		***			****	****	****	
Ammanankuppam	***			***			****	****		
Kavasambattu Colony	***	**		***	**		****	**	****	***
DR Kuppam	**			***			****	****		
Karthambattu		**		***	**		****	***	****	

This table was prepared by the implementers immediately after each day's programe. This is a subjective assessment of the local support provided and the response of the community.

****	Maximum coverage
***	Good response
**	Moderate response
*	Poor response